STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	R-C 11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS AMENDED: 11/1/16 for corrections to all F-tags A revisit was completed 11/14/16 through 11/15/16 following acceptance of an Allegation of Compliance received 11/7/16 to remove the Immediate Jeopardy for F-157 "K", F-224 "L", F-281 "L", F-332 "L", F-333 "L", F-490 "L", F-493 "L", F-501 "L", F-514 "L", and F-520 "L". The revisit revealed the corrective actions implemented with a compliance date of 11/7/16 removed the Immediate Jeopardy, but non-compliance continues at a "E" level Scope and Severity for F-157, and non-compliance continues at a "F" level Scope and Severity for F-224, F-281, F-332, F-333, F-490, F-493, F-501, F-514, and F-520 for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the systemic processes instituted by the facility. F-224, F-332, and F-333 were cited with Substandard Quality of Care. Complaint investigation #39999 was completed at Creekside Health and Rehabilitation Center on 11/14/16-11/15/16. No deficiencies were cited under 42 CFR Part 483 Requirements for Long Term Care Facilities. Complaint Investigation of #39537, #39796, and #39897 were conducted at Creekside Health and Rehabilitation Center on 10/11/16-10/24/16. Deficiencies were cited from the investigation of Complaint #39796 resulting in an Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause,	{F 000}	**F 157- Notification of Change** **1)** The Administrator terminated the contractual agreement with the former Medical Director on 10/25/16. {Exhibit 1} A new contractual agreement with a new Medical Director and NP was established on 10/24/16 to be effective on 10/25/16. {Exhibit 2} RI # 2 Medication Administration Record was reviewed by Director of Nursing on 11/2/16. Medication Administration Record was reviewed by the Director of Nursing on 11/2/16 as vital signs remain stable with no signs of hyper/hypoglycemia {Exhibit 3} Blood sugar results were evaluated for hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. {Exhibit 4} The former Medical Director determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. {Exhibit 5}	**11/17/16**

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	NHA	12/3/16

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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{F 000}	Continued From page 1 serious injury, harm, impairment or death to a resident) for failure to notify physician of abnormal blood glucose; failure to prevent resident neglect due to medication errors; failure to follow care plan; failure to ensure a medication error rate of 5% or less; failure to prevent significant medication errors; failure to ensure documentation was complete and accurate. A partial extended survey was conducted on 10/24/16. The Administrator (NHA) was informed of the Immediate Jeopardy in the Conference Room on 10/24/16 at 3:25 PM. Immediate Jeopardy was cited at F157 K; F224 L; F281 L; F332 L; F333 L; F353 L; F490 L; F493 L; F501 L; F514 K; F520 L. The following were cited with Substandard Quality of Care: F224, F332, and F333. The Immediate Jeopardy was effective 6/4/16 and is ongoing. A follow up of the Plan of Correction from Complaint investigation with an exit date of 8/11/16 was conducted on 10/11/16 and F520 was recited at an L level. The Immediate Jeopardy was effective from 6/4/16 and was removed 11/7/16.	{F 000}	The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 {Exhibit 6} and recommended discontinuation of Lorantadine, Miralax and PRN Clonidine and d/c nifedipine TID . The New Medical Director/Nurse Practitioner reviewed the recommendations and accepted as recommended. {Exhibit 7} The Medication Administration records were updated on 11/2/16 by the Licensed Nurse. {Exhibit 8} The new Medical Director reassessed the resident medication on 11/1/16 with no new orders. {Exhibit 9} The Resident's Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10} RI # 5 no longer resides at the facility. RI #6 Medication Administration Record was reviewed by the Director of Nursing on 11/2/16 as vital signs remain stable with no signs of hyper/hypoglycemia {Exhibit 3} The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. {Exhibit 11} The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. {Exhibit 5}	
{F 157} SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative	{F 157}		

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{F 157}	Continued From page 2 or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to notify the physician of residents with a blood glucose greater than 400 for 5 (Resident #2, #6,#5, #7, #8) of 12 residents reviewed for Diabetes Mellitus. These failures placed all diabetic residents in Immediate Jeopardy (a situation in which the provider's noncompliance with one or	{F 157}	The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 {Exhibit 6} and recommended changes {Exhibit 12} were addressed by the Nurse Practitioner on 11/2/16 with an update to the Medication Administration Record for all accepted orders. The Resident's Responsible Party was notified of any changes to medications. {Exhibit 13}. The new Medical Director reassessed the resident on 11/1/16 with no new orders. {Exhibit 14} The Resident's Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10} RI #7 no longer resides at the facility. RI # 8 Medication Administration Record was reviewed by Director of Nursing on 11/2/16 as vital signs remain stable with no signs of hyper/hypoglycemia. {Exhibit 3} The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 {Exhibit 15} and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. {Exhibit 5} The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 with some changes as recommended. {Exhibit 16}. The New Medical Director conducted a Medication Regimen Review on 11/1/16	

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{F 157}	Continued From page 3 more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death or a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 10/24/16 at 3:15 PM in the Conference Room. The facility provided an acceptable Allegation of Compliance with a compliance date of 11/7/16 and a revisit survey conducted 11/14/16 through 11/15/16 revealed the corrective actions implemented removed the Immediacy of the Jeopardy. Noncompliance for F-157 continues at a "E" level for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the systemic processes instituted by the facility. The findings included: Review of facility policy, Change in Resident's Condition or Status, undated, revealed, "...To insure the proper and timely reporting and documentation of any changes in a resident's condition or status...Nursing services will notify the resident's attending physician when...there is a significant change in the resident's physical, mental or psychosocial status...there is a need to alter the resident's treatment...Deemed necessary or appropriate in the best interest of the resident..." Review of facility policy, Diabetes, Nursing Care of the Adult Diabetes Mellitus Resident, undated revealed,"...The physician should be notified when the blood sugar falls above his/her	{F 157}	{Exhibit 18} and recommended changes were addressed by the Nurse Practitioner on 11/2/16. {Exhibit 17} The Resident's Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10} **2)** On 10/13/16 the former Medical Director was notified during an emergency QA meeting of license staff failure to follow parameters for high and low ranges for insulin, not following physician orders for monitoring and performing finger stick glucose checks as ordered. {Exhibit 19} An additional QA meeting was held on 10/17/16 to discuss auditing. {Exhibit 20} The new Medical Director was notified of the history of nurses not following the ordered parameters for blood sugar level on 10/25/16 and he reviewed records for each of the residents receiving insulin by 11/1/16. **{Exhibit 21}** The new Medical Director also received a copy of the Statement of Deficiencies 2567 on 11/1/16. {Exhibit 22} On 10/25/16, the new Medical Director assumed all physician orders including the new diabetic protocol established on 10/18/16. {Exhibit 23} On 10/15/16, the former Medical Director reviewed 100% of all diabetic patients to ensure adequate blood sugar management. {Exhibit 24} On 11/1/16, the new Medical Director and/or Nurse Practitioner reviewed all residents receiving blood sugar checks, scheduled	

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{F 157}	Continued From page 4 specified blood sugar range and/or above 400 mg/dL (milligrams per deciliter). The Medical Director of the facility is the physician of record for all the residents. Medical record review revealed Resident #2 was admitted to the facility on 6/3/16 with diagnoses including Hypertension, Encephalopathy, Convulsions, Diabetes Mellitus Type II, Mixed Receptive Expressive Language Disorder, Cerebral Vascular Accident, and Dysphagia. Medical record review of a Physician's Order dated 6/4/16 revealed, "...ACCUCHECKS [finger stick for blood sugar] BEFORE BOLUS FEEDINGS AND SSI [sliding scale insulin] AS FOLLOWS: 0-59 = CALL MD [Medical Doctor]...351-400 = 10u...NOTIFY MD AND RECHECK IN 15 MINUTES..." Medical record review of the 6/2016 Medication Administration Record (MAR) for Resident #2 revealed the following blood sugars: 591 on 6/4 at 7:30 AM 432 on 6/6 at 6:00 AM 401 on 6/7 at 12:00 AM High on 6/9 at 12:00 PM 456 on 6/12 at 6:00 AM 429 on 6/18 at 6:00 AM Medical record review revealed no notification of the MD or Nurse Practitioner (NP) regarding the elevated blood sugars. Medical record review of the 7/16 MAR revealed the following blood sugars.	{F 157}	insulin, and sliding scale insulin. {Exhibit 25} On 11/2/16, the Director of Nursing reviewed all current diabetic residents related to blood glucose checks. No resident was identified as having parameters outside of the high and low range, having blood glucose checks completed outside the physician ordered time frame and having sliding scale coverage inappropriately administered according to the sliding scale and patient coverage physician ordered. {Exhibit 3} **3)** On 10/25/16, the pharmacy consultant reviewed 100% of all resident's Medication Regimen including the resident medication administration records for specific drug and risk meds. The Pharmacy recommendations were reviewed by the New Medical Director on 11/2/16. New orders were provided to reflect recommendations that were approved/accepted by the New Medical Director/NP. The Resident's Responsible Party was notified of any changes to medications. On 10/26/16 – 10/29/16, the Director of Nursing/Designee provided focused in-service skills competency training to all licensed nurses on Diabetes, nursing care of the adult Diabetes Mellitus Resident policy, including high and low parameters and physician notification for results	

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{F 157}	Continued From page 5 564 on 7/1 at 6:00 AM 441 on 7/1 at 12:00 PM 503 on 7/6 at 12:00 AM 489 on 7/9 at 12:00 PM 518 on 7/10 at 12:00 AM 511 on 7/10 at 12:00 PM 405 on 7/12 at 12:00 AM 466 on 7/25 at 6:00 AM 459 on 7/27 at 12:00 AM 436 on 7/31 at 6:00 PM Medical record review revealed no notification of the MD or NP regarding the elevated blood sugars. Medical record review of the 8/16 MAR revealed the following blood sugars. 475 on 8/1 at 12:00 AM 492 on 8/7 at 6:00 PM 456 on 8/20 at 6:00 PM 432 on 8/21 at 6:00 PM 493 on 8/25 at 6:00 PM Medical record review revealed no notification of the MD or NP regarding the elevated blood sugars. Medical record review of the 9/16 MAR revealed the following blood sugars. 423 on 9/3 at 12:00 PM 487 on 9/4 at 6:00 PM 47 on 9/7 at 12:00 PM 452 on 9/10 at 12:00 PM 482 on 9/16 at 12:00 AM 434 on 9/17 at 6:00 AM 491 on 9/17 at 12:00 PM 501 on 9/22 at 12:00 PM	{F 157}	outside the physician ordered high/low range, following physician orders for administration of all medications and notification of physician for any variances from orders, to include but not limited to Anti-hypertensive, cardiac medication parameters & MD notification of holding medication only as ordered and medication administration policy. {Exhibit 26} All newly hired licensed nursing staff will complete the comprehensive skills check off in-service program prior to working on the floor. Since 10/25/16 the facility has hired 6 addition new nurses 2 RNs and 4 LPNs. The Human Resource Director/Designee will conduct an audit of the completed skills check off to ensure all newly hired licensed staff have completed the comprehensive skills check off in-service prior to working on the floor. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The facility policy for Diabetes and Nursing Care for the adult Diabetes mellitus was modified to reflect the facility High parameters of 500 on 10/18/16. On 10/25/16, the new Medical Director assumed all physician orders including the newly established diabetic protocol established on 10/18/16.	

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{F 157}	Continued From page 6 560 on 9/23 at 6:00 AM 474 on 9/23 at 12:00 PM 420 on 9/26 at 12:00 AM Medical record review revealed no notification of the MD or NP regarding the elevated blood sugars or the low blood sugar on 9/7/16. Telephone interview with Licensed Practical Nurse (LPN) #5 on 10/18/16 at 4:00 PM revealed, "I did not call the Doctor when the sugar was 560 on 9/23/16." Interview with LPN #6 on 10/19/16 at 7:15 AM, in the conference room confirmed Resident #2's blood sugar was 47 on 9/7/16 and she failed to notify the physician. Medical record review of the 10/2016 MAR revealed a blood sugar of 421 on 10/2 at 6:00 PM. Medical record review revealed no notification of the MD or NP regarding the elevated blood sugar. Interview with the Director of Nursing (DON) on 10/19/16 at 4:05 PM, in the conference room confirmed the facility policy was to notify the physician if a blood sugar was less than 60 or greater than 400. Continued interview with the DON confirmed the facility failed to follow the policy and notify the physician of the elevated blood sugars for Resident #2. Medical record review revealed Resident #6 was admitted to the facility on 9/11/15 and readmitted on 9/19/16 with diagnoses including Schizophrenia, Bipolar Disorder, Diabetes Mellitus, Acute Kidney Failure, Diabetes	{F 157}	The Director of Nursing, Regional Director of Clinical Services and Staff Development Coordinator in-serviced 100% License nurses on facility policy for Diabetes and Nursing Care of the Adult Diabetes Mellitus which includes high and low parameters and physician notification for results outside the physician ordered high and low range, following physician orders for administration of medications, and notifications of physician for any variances from their orders including notification for holding medications. {Exhibit 26} The Clinical Informatics Specialist conducted a search of the electronic medical record related to residents receiving blood sugar checks and identified 23 residents on 10/17/16, 20 residents with scheduled insulin, and 4 residents receiving sliding scale insulin. This list was used to create an audit tool for the Director of Nursing to validate the blood sugars are being done within the ordered time frame, validate the results are documented and validate proper physician notification if the blood sugars levels are outside the low or high parameters. If issues are identified during the audit of all Blood sugars checks, scheduled insulin, and/or Sliding Scale, immediate one on one counseling will be conducted with the Nurses identified failing to follow the physician orders. {Exhibit 27}	

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{F 157}	Continued From page 7 Insipidus, Hypertension, Gastroesophageal Reflux Disease, and Dementia. Medical record review of physician's admission orders dated 9/19/16 revealed Resident #6 was ordered blood glucose monitoring with Sliding Scale Insulin (specific amounts of insulin to be administered depending upon the blood glucose value) before meals and at bedtime. Continued review revealed the order stated if the resident's blood glucose was greater than 400 the nurse was to administer 10 units of insulin and notify the physician. Medical record review of a History and Physical from the hospital dated 9/14/16 revealed Resident #6 was admitted for a blood sugar which was "...measurable high..." Continued review revealed the blood glucose in the Emergency Department was 500 and significant ketosis was present. Medical record review of the blood glucose monitoring sheets and the Medication Administration Record (MAR) revealed on: a. 9/20/16 blood glucose 593 at 9:00 PM b. 9/24/16 blood glucose 405 at 9:00 PM c. 9/29/16 blood glucose 421 at 1:00 PM d. 9/29/16 blood glucose 423 at 5:00 PM e. 10/4/16 blood glucose 405 at 6:15 PM Continued review revealed no documentation the physician was notified of any of these abnormal blood glucose results. Medical record review revealed Resident #5 was admitted to the facility on 10/9/16 with diagnoses including Congestive Heart Failure, End Stage Renal Disease, Hypertension, Diabetes Mellitus,	{F 157}	The Director of Nursing/Designee to conduct an audit of 5 residents receiving blood sugar monitoring with sliding scale &/or insulin administration to validate the blood sugars are being done within the ordered time frame, validate the results are documented and validate proper physician notification if the blood sugars levels are outside the low or high parameters. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee will conduct Medication Administration Observations to ensure the Medication pass is occurring within the scheduled time frames of 60 minutes before or 60 minutes after the ordered medication time. As well as following special parameters for blood pressure and pulse and proper notification documented. If issues are identified during the audit process, immediate counseling will be conducted with the nurse identified to have failed to follow the physician orders. The Medication Administration Audit to be conducted on 10 patients per day 5 days per week X 4 weeks then 20 patients per month X 5 months or until sustained compliance can be reached. Nursing Home Administrator received in-service education by Chief Nursing Officer on the Quality Assurance Performance Improvement Process and how to conduct a root cause analysis and develop a Performance Improvement Plan on 11/15/16.	

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{F 157}	Continued From page 8 and Anxiety. Medical record review of physician's admission orders dated 10/9/16 revealed Resident #5 was ordered to have a blood glucose check each morning. Continued review revealed if the blood glucose was greater than 400 the nurse was to notify the physician. Medical record review of the blood glucose monitoring record and the MAR dated 10/10/16 revealed Resident #5 had a blood glucose of 405 but there is no documentation the physician was notified of the abnormal value. Medical record review revealed Resident #7 was admitted to the facility on 9/29/16 and readmitted on 9/30/16 with diagnoses including Congestive Heart Failure, Cellulitis Left Lower Extremity, Atherosclerotic Cardiovascular Disease, Benign Prostatic Hypertrophy, Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Cor Pulmonale, Atrial Flutter, Chronic Kidney Disease Stage III, and Chronic Obstructive Pulmonary Disease. Medical record review of the physician's admission orders dated 9/29/16 revealed "...blood glucose monitoring before meals and at bedtime. If BS (blood sugar) > (greater than) 400 notify MD and recheck in 15 minutes..." Medical record review of the blood glucose monitoring record and the MAR dated 10/9/16 at 1:46 PM revealed Resident #7 had a blood glucose of 435. Continued review revealed no documentation the physician was notified of the abnormal blood glucose result.	{F 157}	Corporate clinical support conducted daily Medication administration record audits to validate high, low parameters for blood sugars and blood pressures and pulses were followed according to Physician orders. This Audit was conducted 7 days per week at 4am beginning 10/30/16 through 11/15/16 and improved compliance has been noted. The facility has initiated a check out process at the end of each shift to validate Licensed nurse is compliant with documentation of Medication administration according to physician orders and notification of any identified results that were out of the set parameters per physician orders. The check out process started on 11/7/16 by the nursing administration team once sustained compliance is reached the process will be conducted peer to peer at shift change between on-coming nurse and off-going nurse during the shift to shift report process which will include a Medication Administration Review prior to on-coming nurse accepting the keys. Corporate Clinical support continues to randomly review 10 resident Medication Administration Records during their facility visits as a second check to ensure compliance is sustained.	

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{F 157}	Continued From page 9 Medical record review revealed Resident #8 was admitted to the facility on 6/29/16 and readmitted on 8/16/16 with diagnoses including Diabetes Mellitus, Hypertension, Obstructive Sleep Apnea, Seizures, Dysphagia, Gastroesophageal Reflux Disease, and Chronic Pain. Medical record review of physician's admission orders dated 8/16/16 revealed Resident #8 was ordered blood glucose monitoring before meals and at bedtime. Continued review revealed if the blood glucose was greater than 400 the nurse was to notify the physician and recheck the blood glucose in 15 minutes. Medical record review of the blood glucose monitoring record and the MAR dated 9/22/16 revealed Resident #8 had a blood glucose of 408 at 2:35 PM. Continued review revealed there was no documentation the physician was notified of the abnormal blood glucose result. Interview with the Administrator and new Director of Nursing (DON) on 10/24/16 at 11:15 AM, in the Conference Room revealed they had been working on this tag since the last survey with continued education about notification. Continued interview revealed the DON stated she could not say why nurses were still not documenting physician notification. Interview with Nurse Practitioner (NP) #2 on 10/24/16 at 12:20 PM in the conference room revealed she had never been notified of any medications being administered late. Continued interview revealed NP #2 stated if a blood glucose was greater than 400 she would expect the nurse to recheck in 15 to 30 minutes and notify her if it was still elevated.	{F 157}	(4. (a) The Director of Nursing/Designee will report audit findings to the Quality Assurance Performance Improvement Committee in the bi-weekly meeting for Six months. The Quality Assurance Performance Improvement Committee will review the systematic change and audits during the bi-weekly meetings for six months. Some of the Systemic/structural enhancements are: Change in Medical Director, review and approval of new blood glucose protocol, re-organization of medication administration times, pharmacy reviews for 100% of residents to address overall total number of medications per resident, ongoing training and education for medication administration, increase in medication pass reviews, increase cart nurse staffing by (2) FTE on day and evening shifts thereby moving to a (6) cart process, and clinical skills education with return demonstration for 100% of all clinical staff going forward. Any findings with the opportunities for improvement will be analyzed using the fish bone diagram or five why's process to determine the root cause. Once the root cause has been defined, then a more appropriate intervention will be implemented to ensure compliance. (b) The Quality Assurance Performance Improvement Committee, meets at least bi- weekly and includes the Medical Director, Director of Nursing, Administrator, MDS Coordinator, Social Services, Activities Director and	

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{F 157}	Continued From page 10 Validation of the Allegation of Compliance was completed on-site on 11/14/16 through 11/15/16 by review of facility documentation, medical record reviews, and interviews with Nursing and Administration Staff. Surveyors verified the Allegation of Compliance by: 1. Review of the facility's in-service skills competency training records dated 10/26/16 through 10/29/16 to ensure 100% of nursing staff were educated regarding Notification of the Physician and Responsible Party for blood sugar results outside the physician ordered high/low range. 2. Verification through interview with 8 licensed and registered nurses conducted 11/14/16 from 1:40 PM through 5:00 PM and 11/15/16 from 6:30 AM through 8:30 AM of the nurse's understanding of the facility's policies regarding notification of the physician and responsible party for blood sugars outside of the physician prescribed parameters. 3. Review of 10 resident charts with a diagnosis of Diabetes Mellitus to verify documentation of blood sugars and notification of the physician and responsible party if indicated. 4. Verification through interviews, and review of facility documentation on 11/14/16 and 11/15/16 of daily chart audits started on 10/17/16 to include documentation of blood sugars outside the physician ordered high/low range and notification of the physician and responsible party. 5. Verification through interviews with the Administrator on 11/15/16 at 10:40 AM, in the	{F 157}	Maintenance. Un-scheduled Quality Assurance Performance Improvement Committee meetings will be held anytime the need is identified through open discussion and/or areas of concern. If non-compliance is identified, the Quality Assurance Performance Improvement Committee will identify the root cause for the non-compliance, develop a plan to address the non-compliance, study/monitor the plan implemented for its' effectiveness and make changes as indicated. The Committee will continue to monitor interventions for the structural enhancements and monitoring will continue bi-weekly x 6 months. (c). The Regional Director of Clinical Services, Director of Regulatory Compliance, or Regional Director of Clinical Compliance will visit the center to attend a monthly quality assurance performance improvement meeting for six months to ensure that the Plan, Do, Study, Act as part of the Performance Improvement Process (PIP) process is being followed and remains to be effective and improvements continue to be made. Audits have revealed 2 Nurses that continued to struggle to achieve compliance with expectations regarding Medication Administration and Notification processes put in place and have since been terminated and addition 2 nurses received one on one education regarding expectations and subsequently have been placed on Performance improvement plans that are being reviewed weekly with the Director of Nursing Services.	

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{F 157}	Continued From page 11 conference room of the monthly QA meeting held 10/13/16 and 9 Ad Hoc (Immediate) QA meetings since 10/17/16. The facility will remain out of compliance at a Scope and Severity level "E", a deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 157}	**F224- Neglect** **1)** RI # 2 Medication Administration Record was reviewed by licensed nurse on 11/2/16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended discontinuation of Lorantadine, Miralax and PRN Clonidine and d/c nifedipine TID . The New Medical Director/Nurse Practitioner reviewed the recommendations and accepted as recommended and the Medication Administrator records were updated on11/2/16 by the Licensed Nurse. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {See Exhibits 7,8 & 9} RI # 3 Medication Administration Record was reviewed by licensed nurse on 11/2/16 vital signs remain stable with no signs of hyper/hypoglycemia. {Exhibit 3} The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 {Exhibit 28} and recommended to change	11/17/16
{F 224} SS=F	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation of medication pass, and interview, the facility failed to prevent resident neglect when it failed to complete blood glucose monitoring at specified times; failed to administer insulin at scheduled times; failed to administer cardiac, blood pressure, and anti-seizure medications within the scheduled time frame; failed to notify physician of abnormal blood glucose values; failed to follow physician's orders to recheck blood glucose after an abnormal value was found; and failed to document interventions for 12 residents (#2,# 3,# 6,# 5, #7, #8, #9, #10, #4, #11, #12, #13) of 12 residents reviewed for	{F 224}		

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{F 224}	Continued From page 12 medications. These failures placed all diabetic residents in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 10/24/16 at 3:15 PM in the Conference Room. F224 is Substandard Quality of Care The facility provided an acceptable Allegation of Compliance with a compliance date of 11/7/16 and a revisit survey conducted 11/14/16 through 11/15/16 revealed the corrective actions implemented removed the Immediacy of the Jeopardy. Noncompliance for F-224 continues at a "F" level, Substandard Quality of Care, for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the systemic processes instituted by the facility. The findings included: Review of facility policy, Medication Administration, revised 3/16/15 revealed, "...Administer medications within 60 minutes of the scheduled time..." Review of facility policy, Diabetes, Nursing care of the Adult Diabetes Mellitus Resident, undated, revealed, "...The purpose of this guideline is...Prevent recurrence of	{F 224}	medication administration times which were approved for Renvela and Midodrine to 6pm, 2pm, and 10pm and change Prednisone to 8am. The New Medical Director/Nurse Practitioner reviewed the recommendations and accepted as recommended and the Medication Administrator records were updated on 11/2/16 by the Licensed Nurse. {Exhibit 29} The new Medical Director reassessed the resident on 11/1/16 with no new orders. {Exhibit 30} The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10} RI # 5 No longer resides at the facility. RI #6 Medication Administration Record was reviewed by licensed nurse on 11/2/16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and RI # 18 was assessed by licensed nurse on 10/19/16 vital signs remain stable with no signs of any negative findings regarding Wound Vac then NP reviewed the resident and verified the orders. Was also assessed/evaluated by the New MD/NP on 11/1/16 and found to	

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{F 224}	Continued From page 13 hyperglycemia/hypoglycemia [high and low blood sugars]. Recognize, assist and document the treatment of complications commonly associated with diabetes...obtain pre-meal fingerstick blood glucose within 60 minutes (maximum) of anticipated meal...The physician should be notified when the blood sugar falls above his/her specified blood sugar range and/or above 400 mg/dL (milligrams per deciliter)..." Review of facility policy, Guidelines for Medications, undated, revealed "...All blood sugars that are less than 60 or greater than 400 must be rechecked in 15 minutes and documented..." The Medical Director of the facility is the physician of record for all the residents. Medical record review revealed Resident #2 was admitted to the facility on 6/3/16 with diagnoses including Hypertension, Encephalopathy, Convulsions, Diabetes Mellitus Type II, Mixed Receptive Expressive Language Disorder, Cerebral Vascular Accident, and Dysphagia. Medical record review of a Quarterly Minimum Data Set (MDS) dated 9/9/16 revealed the resident had a Brief Interview for Mental Status (BIMS) of 4/10 due to the inability of the resident to complete the interview, indicating the resident was severely cognitively impaired. She received 51% or more of her calories, 500 cc (cubic centimeters) or more of fluid through a feeding tube, and received 7 injections of insulin during the previous 7 days. Medical record review of a Physician's Order for Resident #2 dated 6/4/16 revealed,	{F 224}	be in stable condition with no negative outcome identified. Wound Vac was discontinued on10/26/16. {See Exhibit 12, 13, & 14} RI #7 No longer resides at the facility. RI # 8 Medication Administration Record was reviewed by licensed nurse on 11/2/16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 with some changes as recommended. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse.{See Exhibit 15, 16, 17, & 18} RI # 9 Medication Administration Record was reviewed by licensed nurse on 11/2/16 vital signs remain stable with no signs of hyper/hypoglycemia. {Exhibit 3} The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 {Exhibit 31} and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed	

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{F 224}	Continued From page 14 "...ACCUCHECKS [finger stick for blood sugar] BEFORE BOLUS FEEDINGS AND SSI [sliding scale insulin] AS FOLLOWS: 0-59 = CALL MD (Medical Doctor) 60-150=0, 151-200=2u [units], 201-250=4u, 251-300=6u, 301-350=8u, 351-400 = 10u...NOTIFY MD AND RECHECK IN 15 MINUTES..." The scheduled time was 6 AM, 12 PM, 6 PM, and 12 AM daily. Medical record review of the 6/2016 Medication Administration Record (MAR) for Resident #2 revealed a blood sugar of 211 on 6/4/16 at 5:00 PM and no SSI was administered. Continued review revealed blood sugars were checked 1-4 hours late 2 times for the month of 6/16. Interview with Licensed Practical Nurse (LPN) #3 on 10/18/16 at 2:20 PM in the conference room revealed he called Nurse Practitioner (NP) #2 on 6/4/16 regarding Resident #2's blood sugar of 211 and was told to hold the SSI dose of 4 units. The LPN confirmed he did not write an order to hold the 4 units of insulin and he did not administer the dose per the sliding scale protocol. Medical record review of Resident #2's 7/2016 MAR revealed blood sugars were checked 19 minutes-3 hours late 5 times for the month of 7/2016. The time frame excludes the window of time which is allowable to administer medication 60 minutes before or 60 minutes after the scheduled time. Medical record review of Resident #2's 9/2016 MAR revealed blood sugars were checked 50 minutes-1 hour and 38 minutes late 2 times for the month of 9/2016. Medical record review of the 10/2016 MAR for	{F 224}	to be increased to 500 threshold on 10/18/16. {Exhibit 5} The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 {Exhibit 32} and recommended increase lantus to 25 units at 9:00 pm and make accuchecks at QDay and PRN only. Denied by MD on 11/1/16. The new Medical Director reassessed the resident on 11/1/16 {Exhibit 25} with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10} RI # 10 Medication Administration Record was reviewed by licensed nurse on 11/2/16 {Exhibit 3} vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 {Exhibit 33} and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. {Exhibit 5} The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended increase Trazodone to 100 mg PO 8pm and DC Seroquel 50 mg hs. {Exhibit 34}. MD denied recommendation. The new Medical Director reassessed the resident on 11/1/16 with no new orders. {Exhibit 25} The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10}	

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{F 224}	Continued From page 15 Resident #2 revealed blood sugars were checked 17 minutes-4 hours and 35 minutes late 8 times from 10/1-10/20/16 and checked 1 hour and 26 minutes early on 10/8/16. Medical record review of Resident #2's Physician's Orders for Resident #2 dated 9/22/16 revealed an order for Lantus (long acting insulin) 21 units subcutaneously (layer of skin insulin is injected into) at bedtime every night. The order for Lantus 21 units was discontinued on 9/26/16 when the Lantus was increased to 24 units subcutaneously (given under the skin) at bedtime every night on 9/26/16. The scheduled administration time was 9:00 PM. Continued medical record review of the 9/2016 MAR revealed Resident #2's blood sugar was 501 on 9/22 at 12:00 PM and she received 10 units of insulin per the SSI protocol at 2:49 PM. There was no documentation the blood sugar was re-checked in 15 minutes after administration of the 10 units of SSI. The blood sugar was not checked at 6:00 PM per order and the 21 units of Lantus insulin was not administered at 9:00 PM on 9/22/16 per order. The blood sugar was 327 at 12:00 AM on 9/23 and no SSI was administered; the blood sugar was 560 at 6:00 AM and no SSI was administered, the blood sugar was not re-checked in 15 minutes, and the physician was not notified. Continued review revealed no physician orders to hold accuchecks, Lantus insulin, or SSI in Resident #2's medical record. Medical record review of an e-MAR (electronic Medication Administration Record) narrative Administration Record note for Resident #2 dated 9/22/16 at 7:20 PM by Registered Nurse (RN) #2	{F 224}	RI # 4 Medication Administration Record was reviewed by licensed nurse on 11/2/16 with {Exhibit 3} with vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 {Exhibit 35} and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. {Exhibit 5} The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16, recommended changes were accepted {Exhibit 36} and made by the licensed nurse. {Exhibit 37} The new Medical Director reassessed the resident on 11/1/16 with no new orders. {Exhibit 25} The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10} RI # 11 Medication Administration Record was reviewed by licensed nurse on 11/2/16 {Exhibit 3} with vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and an assessed/evaluated by the MD/NP on 10/18/16 {Exhibit 38} and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. {Exhibit 5} The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended changes were reviewed and	

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{F 224}	Continued From page 16 revealed, "...ACCUCHECK...scheduled for 09/22/2016 6:00 PM. verbally ordered to hold insulin per NP #1..." Continued review of a note dated 9/22/16 at 9:44 PM by RN #2 revealed, "...LANTUS...scheduled for 09/22/2016 9:00 PM. Ordered to hold per NP #1..." Continued review revealed the blood glucose was 327 at 1:50 AM and a note dated 9/23/16 at 1:50 AM by LPN #5 revealed, "...insulin held as ordered..." The blood glucose was 560 at 5:16 AM and a note on 9/23/16 at 5:16 AM from LPN #5 revealed, "...insulin held for lab work this am..." Review of a physician's order dated 9/22/16 revealed A1C (blood test to determine average glucose over 3 months) in AM. Interview with NP #1 on 10/12/16 at 12:38 PM in the conference room revealed, when asked if insulin needed to be held prior to drawing A1C labwork, the NP stated, "Absolutely not." Continued interview with the NP revealed she was aware the insulin had not been given to Resident #2 when she rounded (visited residents) on 9/23/16. The NP denied giving a verbal order to Registered Nurse (RN) #2 to hold insulin on the resident on 9/22/16. She stated, "I only met [RN #2] the one time during shift change. [LPN #4] and I had been dealing with [Resident #2's] hyperglycemia (high blood sugar) issues during that day. I absolutely did not give a verbal order to hold insulin and no one called me when it was 560. What I wanted done was to wait until 7 PM to give the next tube feeding bolus as the previous one was given around 2 or 3 PM. I was here when the blood sugar was 501 and [LPN #4] gave 10 units, rechecked it and it was still high. I believe we may have given another 10 units of insulin after that. It makes no sense to hold	{F 224}	approved. {Exhibit 39} Please note telephone order {Exhibit 40}. The new Medical Director reassessed the resident on 11/1/16 with no new orders. {Exhibit 25} The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10} RI # 12 No longer resides at the facility. RI # 13 No longer resides at the facility. **2)** We acknowledge residents who receive blood glucose monitoring & insulin administration had the potential to be affected by the alleged deficient practice. An audit was conducted on 10/17/16 by the Regional Director of Clinical Services of current residents and identified additional residents that had the potential to be affected by the alleged deficient practice. {Exhibit 27} We acknowledge residents who receive Anti-Hypertensive medications had the potential to be affected by the alleged deficient practice. An audit was conducted on 10/31/16 by the Regional Director of Clinical Services of current residents and identified additional residents that had the potential to be affected by the alleged deficient practice. {Exhibit 41} The Medication Administration Records for all residents receiving insulin and/or Sliding Scale coverage, Anti-hypertensive medications, Cardiac Medications, Anti-anxiety medications, Anti-Depressant	

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{F 224}	Continued From page 17 insulin when the blood sugars had been high that day." Further interview and medical record review with the NP confirmed "there was no written telephone order and no computerized order by LPN #4 to give another 10 units of insulin, no order to hold the Lantus insulin dose at 9:00 PM, and no order to hold any SSI (Sliding Scale Insulin - specific amount of insulin administered according to blood glucose result) at 12:00 AM or 6:00 AM." Interview with LPN #4 on 10/12/16 at 2:05 PM, in the conference room revealed she notified NP #1 on 9/22/16 when Resident #2's blood sugar was 501 and was told to give 10 units of insulin, wait 30 minutes and re-check it again. The LPN stated "when she re-checked the blood glucose 30 minutes later the blood glucose was higher than 501 and the NP told her to give an additional 12 units of insulin and recheck it after that." Continued interview with LPN #4 revealed she checked it after administering 12 units and the blood glucose was in the 300's and stated she notified the NP and was told to go ahead and give the tube feeding now." The LPN was not sure of the exact time but stated it was around 2 or 3 in the afternoon. Further interview with LPN #4 revealed "I told [RN #2] I didn't give the 6 o'clock tube feeding, and to give it at 7 PM because the 12 o'clock dose was given later in the afternoon because of the blood sugars." Continued interview with LPN #4 confirmed she failed to write an order to administer an additional 12 units of insulin on 9/22/16; failed to document the results of the blood sugars when she rechecked them twice; and failed to document she had notified the NP for a blood glucose of 501 and higher for Resident #2.	{F 224}	medications and all medications requiring vital signs monitoring were reviewed for October 2016 by the Regional Director Clinical Service from 10/28/16 thru 11/1/16 {Exhibit 42} to ensure special requirements for high and low parameters were being followed as ordered by the physician and Medication Administration Record's for holes indicating missing medication and failure to follow physician orders. On 10/13/16 the former Medical Director was notified of license staff failure to follow parameters for high and low ranges for insulin, not following physician orders for monitoring and performing finger stick glucose checks as ordered during an emergency QA meeting **{Exhibit 19}.** An additional QA meeting was held on 10/17/16 {Exhibit 20} The new Medical Director was notified of the history of nurses not following the ordered parameters for blood sugar level on 11/1/16 and he reviewed each of the resident receiving insulin and current medications. {Exhibit 25} On 10/15/16 the Medical Director reviewed 100% of all diabetic patients to ensure adequate blood sugar management. {Exhibit 24} On, 11/1/16, the new Medical Director and/or Nurse Practitioner reviewed all residents receiving blood sugar checks, scheduled insulin, and sliding scale insulin. {Exhibit 25} On 11/2/16, the Director of Nursing reviewed all current residents related to blood glucose checks. {Exhibit 43} No resident was identified as having	

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{F 224}	Continued From page 18 Telephone interview with RN #2 on 10/12/16 at 3:20 PM revealed, "The NP was rounding when I was taking over the cart around 6:30 or 7 PM. She told me to hold 1 dose of insulin for [Resident #2] because her blood sugar had been low. I don't know why the other nurse held the insulin as it is not indicated for an A1C." Continued interview with RN #2 confirmed he did not write a telephone order to hold 1 dose of insulin and did not put an order in the computer and stated, "I didn't know how to make it a physician's order in the computer." Telephone interview with LPN #5 on 10/18/16 at 4:00 PM revealed, "(RN #2) gave me report to hold the insulin for lab work in the morning. I should have looked to see the order myself, and I did not call the Doctor when [Resident #2's] sugar was 560. I was just going on what I was told." Medical record review revealed Resident #3 was admitted to the facility on 7/5/16 and readmitted on 9/22/16 with diagnoses including Anoxic Brain Injury, Respiratory Failure, Diabetes Mellitus Type II, Chronic Kidney Disease Stage IV, Aphasia, Anxiety, Depression and a History of Multiple Myeloma. Medical record review of an Admission MDS dated 7/12/16 revealed the resident was severely cognitively impaired, had impairments to all extremities, received insulin 1 time over the previous 7 days, received 51% or greater of his calories, and 501 cc per day of fluid through a feeding tube. Medical record review of a telephone physician's order dated 9/22/16 revealed, "...Accuchecks before meals and at bedtime..." The scheduled	{F 224}	parameters outside of the high and low range, blood glucose checks were completed within the physician ordered time frame and sliding scale coverage was appropriately administered, according to the sliding scale and patient coverage physician ordered. Medical Director made adjustments to the high parameters for Blood sugar levels to increase to 500 before notifying the physician/nurse practitioner on 10/18/16. {Exhibit 5} Between 10/31/16 and 11/1/16 the new Medical Director and/or Nurse Practitioner reviewed all residents receiving blood sugar checks, scheduled insulin, and sliding scale insulin. {Exhibit 25} On 11/2/16 the Director of Nursing reviewed all current residents related to blood glucose checks, scheduled insulin and sliding scale insulin. No resident was identified as having parameters outside of the high and low range, blood glucose checks were completed within the physician ordered time frame and sliding scale coverage was appropriately administered, according to the sliding scale and patient coverage physician ordered. {Exhibit 43} 3) On 10/26/16 and 10/29/16 the Director of Nursing/Designee provided focused in-service skills competency training to licensed nurses on Diabetes, including high and low parameters and physician notification for results outside the physician ordered high/low range.	

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{F 224}	Continued From page 19 time of administration was 7:30 AM, 12:00 PM, 5:00 PM, and 9:00 PM. The order did not include sliding scale insulin (SSI) orders. Medical record review of the 9/16 MAR revealed Resident #3's blood sugar was scheduled to be checked at 9:00 PM and was checked at 11:43 PM on 9/22, and scheduled to be checked at 7:30 AM on 9/23 and was checked at 1:22 PM. Medical record review revealed no telephone physician orders regarding accuchecks, SSI, or administration time changes. Medical record review of the Physician's Recapitulation Orders for 9/2016 revealed an order dated 9/23/16 for accuchecks with SSI. The scheduled times were 10:00 AM, 2:00 PM, 6:00 PM and 10:00 PM. Medical record review of the 9/2016 and 10/2016 MAR revealed blood sugars were checked late as follows for Resident #3: 9/24 scheduled at 10:00 AM checked at 3:05 PM 9/24 scheduled at 2:00 PM checked at 4:20 PM 9/25 scheduled at 10:00 AM checked at 3:38 PM 9/25 scheduled at 2:00 PM checked at 5:33 PM 9/25 scheduled at 10:00 PM checked at 11:23 PM 9/26 scheduled at 10:00 AM checked at 12:39 PM 9/26 scheduled at 2:00 PM checked at 3:28 PM 9/26 scheduled at 10:00 PM checked at 5:20 AM on 9/27 9/28 scheduled at 10:00 AM checked at 11:19 AM 9/28 scheduled at 2:00 PM checked at 4:04 PM 9/28 scheduled at 10:00 PM checked at 11:36 PM 9/29 scheduled at 10:00 AM checked at 3:19 PM 9/29 scheduled at 2:00 PM checked at 3:20 PM	{F 224}	Following physician orders for administration of all medications and notification of physician for any variances from orders, Anti-hypertensive, Cardiac medication parameters & MD notification of holding medication if ordered and medication administration policy. {Exhibit 26} Since 10/25/16 the facility has hired 6 additional new nurses 2 RNs and 4 LPNs. Nursing Home Administrator received in-service education by Chief Nursing Officer on the Quality Assurance Performance Improvement Process and how to conduct a root cause analysis and develop a Performance Improvement Plan on 11/15/16. Corporate clinical support conducted daily Medication administration record audits to validate high, low parameters for blood sugars and blood pressures and pulses were followed according to Physician orders. This Audit was conducted 7 days per week at 4am beginning 10/30/16 through 11/15/16 and improved compliance has been noted. The facility has initiated a check out process at the end of each shift to validate Licensed nurse is compliant with documentation of Medication administration according to physician orders and notification of any identified results that were out of the set parameters per physician orders. The check out process started on 11/7/16 by the nursing administration team once sustained compliance is reached the process will be	

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{F 224}	Continued From page 20 10/4 scheduled at 2:00 PM checked at 6:08 PM Medical record review of a physician's telephone order dated 9/12/16 revealed, "...Midodrine HCL [used to treat low blood pressure] 5 mg tab [tablet] give one tab PT [per tube] before meals; BP [blood pressure] to be checked prior to administration, Hold for BP [systolic greater than 120 or diastolic greater than 80]..."The order was written by LPN #4 and signed by NP #1. Medical record review of the Electronic Physician's Order dated 9/12/16 for Midodrine 5 mg revealed it was entered into the computer by LPN #4 at 7:00 PM. The electronic order contained a special requirement to check the blood pressure prior to administration and to hold if the systolic blood pressure was less than 120. Medical record review of 9/2016 MAR revealed a physicians order dated 9/12/16 for "...MIDODRINE HCL 5 MG TABLET give one tablet per tube before meals. CHECK BP [blood pressure]..." There were no blood pressure parameters transcribed onto the MAR. Medical record review of the 9/2016 MAR revealed Midodrine 5 mg was administered to the resident with the following BP's documented. 9/12 at 10:00 PM. BP 149/90 9/13 at 10:00 AM. BP 152/82 9/13 at 2:00 PM. BP 125/64 9/13 at 6:00 PM BP 122/80 9/13 at 10:00 PM. BP 124/53 9/14 at 10:00 AM. BP 134/70 9/14 at 2:00 PM. BP 130/70 9/14 at 6:00 PM. BP 134/70 9/14 at 10:00 PM. BP 129/82	{F 224}	conducted peer to peer at shift change between on-coming nurse and off-going nurse during the shift to shift report process which will include a Medication Administration Review prior to on-coming nurse accepting the keys. Corporate Clinical support continues to randomly review 10 resident Medication Administration Records during their facility visits as a second check to ensure compliance is sustained. The Director of Nursing/Designee to conduct an audit of 5 residents receiving blood sugar monitoring with sliding scale &/or insulin administration to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct an audit of 5 residents receiving Anti-Hypertensive medications to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct an audit of 5 residents receiving Cardiac medications to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached.	

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{F 224}	Continued From page 21 9/15 at 10:00 AM. BP 126/75 9/15 at 2:00 PM. BP 128/75 9/16 at 10:00 AM. BP 120/100 9/16 at 2:00 PM. BP 118/88 Continued review of an Electronic Physician's Order dated 9/16/16 revealed LPN #3 removed the parameter to hold the Midodrine 5 mg if the systolic blood pressure was less than 120 on 9/16/16 at 5:01 PM. The original parameters from the 9/12/16 order to hold the medication if the systolic BP was greater than 120 or the diastolic BP was greater than 80 was not entered into the computer or transcribed onto the MAR. Medical record review of the MAR revealed Midodrine 5 mg was administered to Resident #3 from 9/16 at 6:00 PM-9/20 at 6:00 PM without knowledge if the resident was hypotensive and required the medication as there was no documentation of blood pressures during this time frame. Interview with the Director of Nursing (DON) on 10/19/16 at 4:05 PM, in the conference room revealed the DON was aware medications were being administered outside the 2 hour window, 60 minutes before and 60 minutes after the scheduled time allowed for medication administration. Continued interview with the DON confirmed administering medications greater than the 2 hour window was a medication error and stated "It's not acceptable." The DON confirmed the blood pressure parameters for the 9/12/16 Midodrine 5 mg order for Resident #3 had been entered into the computer incorrectly and the medication was administered to the resident when it should not have been. Continued interview confirmed the correct blood pressure	{F 224}	The Director of Nursing/Designee to conduct Medication Administration Observation to ensure Physician Orders are being followed and Medications are being administered timely with 5 license nurses per week X 4 weeks then monthly X 5 months or until sustained compliance can be reached. (4. (a) The Director of Nursing/Designee will report audit findings to the Quality Assurance Performance Improvement Committee in the bi-weekly meeting for six months. The Quality Assurance Performance Improvement Committee will review the systematic change and audit bi-weekly for six months. Some of the Systemic/structural enhancements are: Change in Medical Director, review and approval of new blood glucose protocol, re-organization of medication administration times, pharmacy reviews for 100% of residents to address overall total number of medications per resident, ongoing training and education for medication administration, increase in medication pass reviews, increase cart nurse staffing by (2) FTE on day and evening shifts thereby moving to a (6) cart process, and clinical skills education with return demonstration for 100% of all clinical staff going forward. Any findings with the opportunities for improvement will be analyzed using the fish bone diagram or five why's process to determine the root cause. Once the root	

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{F 224}	Continued From page 22 parameters should have been entered on 9/16/16 and were not. Further interview revealed the DON confirmed when a blood sugar or blood pressure was not documented prior to administering or holding insulin or a blood pressure medication as ordered it was a medication error. The DON confirmed the facility failed to check blood sugars as scheduled, failed to follow the facility policy to administer medications within the 2 hour window, failed to enter BP orders into the computer correctly, and failed to document blood sugars and/or blood pressure readings, resulting in significant medication errors for Resident #2 and #3. Medical record review revealed Resident #5 was admitted to the facility on 10/9/16 with diagnoses including Congestive Heart Failure, End Stage Renal Disease, Hypertension, Diabetes Mellitus, and Anxiety. Medical record review of the MAR for October 2016 revealed: a. on 7 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 4 occasions insulin was administered 1 1/2 - 2 hours past the scheduled window. c. on 6 occasions Metformin was administered 1 1/2 - 3 hours past the scheduled window. Medical record review of physician's admission orders dated 10/9/16 revealed Resident #5 was ordered to have a blood glucose check each morning. Continued review revealed if the blood glucose was greater than 400 the nurse was to notify the physician. Medical record review of the blood glucose	{F 224}	cause has been defined, then a more appropriate intervention will be implemented to ensure compliance. (b) The Quality Assurance Performance Improvement Committee, meets at least bi-weekly and at a minimum, includes the Medical Director, Director of Nursing, Administrator, MDS Coordinator, Social Services, Activities Director and Maintenance. Un-scheduled Quality Assurance Performance Improvement Committee meetings will be held anytime the need is identified through open discussion and/or areas of concern. If non-compliance is identified, the Quality Assurance Performance Improvement Committee will identify the root cause for the non-compliance, develop a plan to address the non-compliance, study/monitor the plan implemented for its' effectiveness and make changes as indicated. The Committee will continue to monitor interventions for the structural enhancements and monitoring will continue bi-weekly x 6 months. (c). The Regional Director of Clinical Services, Company Director of Regulatory Compliance, or Regional Director of Clinical Compliance will visit the center to attend a monthly quality assurance performance improvement meeting for three months to ensure that the Plan, Do Study, Act process is being followed and remains to be effective and improvements continue to be made. Audits have revealed 2 Nurses that continued to struggle to achieve compliance with expectations regarding Medication Administration and	

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{F 224}	Continued From page 23 monitoring record and the MAR dated 10/10/16 revealed Resident #5 had a blood glucose of 405 and no documentation the physician was notified of the abnormal value. Continued review revealed no documentation the blood glucose was rechecked in 15 minutes per physician orders and facility policy. Medical record review revealed Resident #6 was admitted to the facility on 9/11/15 and readmitted on 9/19/16 with diagnoses including Schizophrenia, Bipolar Disorder, Diabetes Mellitus, Acute Kidney Failure, Diabetes Insipidus, Hypertension, Gastroesophageal Reflux Disease, and Dementia. Medical record review of a History and Physical from the hospital dated 9/14/16 revealed Resident #6 was admitted for a blood sugar which was "...measurable high..." Continued review revealed the blood glucose in the Emergency Department was 500 and significant ketosis was present. Medical record review of the Medication Administration Record (MAR) for September 2016 revealed: a. on 22 occasions blood glucose monitoring was completed from 1 1/2 - 7 hours past the scheduled window of 60 minutes after the scheduled time b. on 12 occasions insulin was administered 1 1/2 - 7 hours past the scheduled window c. on 7 occasions Rocephin (antibiotic) was administered 2 - 8 1/2 hours past the scheduled window. Medical record review of the MAR for October 2016 revealed:	{F 224}	**Notification processes put in place and have since been terminated and additional** 2 nurses received one on one education regarding expectations and subsequently have been placed on Performance Improvement Plans that are being reviewed weekly with the Director of Nursing Services.	

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{F 224}	Continued From page 24 a. on 33 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 2 occasions insulin was administered 1/2 - 1 1/2 hours past the scheduled window c. on 4 occasions Cymbalta (antidepressant) was administered 2 - 3 hours past the scheduled window d. on 4 occasions Trazodone (antidepressant) was administered 1/2 - 3 hours past the scheduled window e. on 9 occasions Buspirone (anti-anxiety) was administered 1 1/2 - 4 hours past the scheduled window Medical record review of physician's admission orders dated 9/19/16 revealed Resident #6 was ordered blood glucose monitoring with Sliding Scale Insulin before meals and at bedtime. Continued review revealed the order stated if the resident's blood glucose was greater than 400 the nurse was to administer 10 units of insulin and notify the physician. Medical record review of the blood glucose monitoring sheets and the Medication Administration Record (MAR) revealed on: a. 9/20/16 blood glucose 593 at 9:00 PM b. 9/24/16 blood glucose 405 at 9:00 PM c. 9/29/16 blood glucose 421 at 1:00 PM d. 9/29/16 blood glucose 423 at 5:00 PM e. 10/4/16 blood glucose 405 at 6:15 PM Continued review revealed no documentation the physician was notified of any of these abnormal blood glucose results. Further review revealed no documentation the blood glucose was rechecked in 15 minutes on each of these occasions per physician order and facility policy.	{F 224}		

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{F 224}	Continued From page 25 Medical record review revealed Resident #5 was admitted to the facility on 10/9/16 with diagnoses including Congestive Heart Failure, End Stage Renal Disease, Hypertension, Diabetes Mellitus, and Anxiety. Medical record review of the MAR for October 2016 revealed: a. on 7 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 4 occasions insulin was administered 1 1/2 - 2 hours past the scheduled window. c. on 6 occasions Metformin was administered 1 1/2 - 3 hours past the scheduled window. Medical record review revealed Resident #7 was admitted to the facility on 9/29/16 and readmitted on 9/30/16 with diagnoses including Congestive Heart Failure, Cellulitis Left Lower Extremity, Atherosclerotic Cardiovascular Disease, Benign Prostatic Hypertrophy, Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Cor Pulmonale, Atrial Flutter, Chronic Kidney Disease Stage III, and Chronic Obstructive Pulmonary Disease. Medical record review of the MAR for October 2016 revealed: a. on 18 occasions blood glucose monitoring was completed 1 1/2 - 3 hours past the scheduled window b. on 16 occasions insulin was administered 2 1/2 - 8 hours past the scheduled window c. on 5 occasions Cardizem (cardiac) was administered 3 1/2 - 6 hours past the scheduled window	{F 224}		

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{F 224}	Continued From page 26 d. on 9 occasions Metoprolol (blood pressure) was administered 1 1/2 - 3 hours past the scheduled window e. on 5 occasions Lisinopril (blood pressure) was administered 1 1/2 - 3 hours past the scheduled window f. on 3 occasions Elavil (antianxiety) was administered 1 1/2 - 2 1/2 hours past the scheduled window Medical record review of the physician's admission orders dated 9/29/16 revealed "...blood glucose monitoring before meals and at bedtime. If BS (blood sugar) > (greater than) 400 notify MD and recheck in 15 minutes..." Medical record review of the blood glucose monitoring record and the MAR dated 10/9/16 at 1:46 PM, revealed Resident #7 had a blood glucose of 435. Continued review revealed no documentation the physician was notified of the abnormal blood glucose result and no documentation the blood glucose was rechecked after 15 minutes per physician orders and facility policy. Medical record review revealed Resident #8 was admitted to the facility on 6/29/16 and readmitted on 8/16/16 with diagnoses including Diabetes Mellitus, Hypertension, Obstructive Sleep Apnea, Seizures, Dysphagia, Gastroesophageal Reflux Disease, and Chronic Pain. Medical record review of the MAR for September 2016 revealed: a. on 54 occasions blood glucose monitoring was completed 1 1/2 - 8 1/2 hours past the scheduled window b. on 18 occasions Clonidine (blood pressure)	{F 224}		

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{F 224}	Continued From page 27 was administered 1 1/2 - 5 hours past the scheduled window c. on 13 occasions Celexa (antidepressant) was administered 1 1/2 - 5 1/2 hours past the scheduled window d. on 14 occasions Trazodone (antidepressant) was administered 1 1/2 - 4 1/2 hours past the scheduled window e. on 3 occasions Coreg (cardiac) was administered 1 1/2 - 2 1/2 hours past the scheduled window f. on 1 occasion Lexothyroxine (thyroid) and Zantac (antacid) were administered 10 1/2 hours past the scheduled window Medical record review of the MAR for October 2016 revealed: a. on 31 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 4 occasions insulin was administered 2 - 5 hours past the scheduled window c. on 20 occasions Clonidine was administered 1 1/2 - 7 /12 hours past the scheduled window d. on 11 occasions Celexa was administered 2 - 3 hours past the scheduled window e. on 13 occasions Trazodone was administered 1 1/2 - 5 hours past the scheduled window. Medical record review of physician's admission orders dated 8/16/16 revealed Resident #8 was ordered blood glucose monitoring before meals and at bedtime. Continued review revealed if the blood glucose was greater than 400 the nurse was to notify the physician and recheck the blood glucose in 15 minutes. Medical record review of the blood glucose monitoring record and the MAR dated 9/22/16	{F 224}		

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{F 224}	Continued From page 28 revealed Resident #8 had a blood glucose of 408 at 2:35 PM. Continued review revealed there was no documentation the physician was notified of the abnormal blood glucose result. Further review revealed no documentation the blood glucose was rechecked in 15 minutes per physician orders and the facility policy. Medical record review revealed Resident #9 was admitted to the facility on 4/22/16 and readmitted on 5/11/16 with diagnoses including Acute/Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Obstructive Sleep Apnea, Atrial Fibrillation, Hypertension, Congestive Heart Failure, Seizures, Dementia, and Atherosclerotic Cardiovascular Disease. Medical record review of the MAR for September 2016 revealed: a. on 30 occasions blood glucose monitoring was completed 1 1/2 - 7 hours past the scheduled window b. on 20 occasions insulin was administered 1 1/2 - 7 hours past the scheduled window c. on 43 occasions Buspirone (antianxiety) was administered 1 1/2 - 5 hours past the scheduled window. d. on 16 occasions Cymbalta (antidepressant) was administered 1 1/2 - 5 hours past the scheduled window e. on 16 occasions Trazodone (antidepressant) was administered 1 1/2 - 5 hours past the scheduled window Medical record review of the MAR for October 2016 revealed: a. on 13 occasions blood glucose monitoring was completed 1 1/2 - 4 hours past the scheduled	{F 224}		

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{F 224}	Continued From page 29 window b. on 6 occasions insulin was administered 1 1/2 - 3 1/2 hours past the scheduled window c. on 19 occasions Buspirone was administered 1 1/2 - 2 1/2 hours past the scheduled window d. on 8 occasions Cymbalta was administered 1 1/2 - 3 1/2 hours past the scheduled window e. on 8 occasions Trazodone was administered 1 1/2 hours - 3 1/2 hours past the scheduled window Medical record review revealed Resident #10 was admitted to the facility on 5/6/16 with diagnoses including Hypertension, Diabetes Mellitus, Dementia, Atherosclerotic Cardiovascular Disease, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Ischemic Cardiomyopathy, and Bipolar Disorder. Medical record review of the MAR for September 2016 revealed: a. on 47 occasions blood glucose monitoring was completed 1 1/2 - 7 hours past the scheduled window. Medical record review of the MAR for October 2016 revealed: a. on 34 occasions blood glucose monitoring was completed 1 1/2 - 7 1/2 hours past the scheduled window. Medical record review revealed Resident #4 was admitted to the facility on 5/19/14 with diagnoses including Multiple Sclerosis, Diabetes Mellitus, Depression, Hypertension, and Congestive Heart Failure. Medical record review of the MAR for October	{F 224}		

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{F 224}	Continued From page 30 2016 revealed: a. on 21 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window.. Medical record review revealed Resident #11 was admitted to the facility on 10/6/16 and readmitted on 10/14/16 with diagnoses including Chronic Kidney Disease Stage III, Obesity, Chronic Respiratory Failure, Pulmonary Embolus, and Diabetes Mellitus. Medical record review of the Medication Administration Record (MAR) on 10/19/16 during medication pass revealed Resident #11 was ordered: a. blood glucose check at 7:30 AM b. Humalog Insulin according to the blood glucose at 7:30 AM c. Zantac (antacid) 150 milligrams (mg) due at 9:00 AM d. Gemfibrozil (hyperlipidemia) 600 mg due at 9:00 AM e. Diamox (glaucoma) 250 mg due at 9:00 AM f. Doxycycline (antibiotic)100 mg due at 10:00 AM g. Eliquis (anticoagulant) 10 mg due at 10:00 AM h. Prednisone (steroid) 5 mg due at 10:00 AM Observation during the medication pass which began at 11:00 AM, revealed RN #3 administered all of the medications and completed the blood glucose check at 11:15 AM. Medical record review revealed Resident #12 was admitted to the facility on 10/14/16 with diagnoses including Obesity and Post Laminectomy Syndrome. Medical record review of the MAR dated 10/19/16	{F 224}		

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{F 224}	Continued From page 31	{F 224}		

revealed Resident #12 was ordered
a. Dyazide (diuretic) 37.5/25 mg at 8:00 AM
b. Lasix (diuretic) 40 mg at 9:00 am
c. Verapamil (cardiac) 240 mg at 9:00 AM
d. Potassium Chloride (replacement) 20 milliequivalents at 9:00 AM
e. Colace (stool softener) 100 mg at 10:00 AM
f. Doxycycline (antibiotic) 100 mg at 10:00 AM
g. Ceftriaxone (antibiotic) 2 grams intravenously at 10:00 AM

Observation during the medication pass revealed RN #3 administered all of the medications at 12:05 PM.

Medical record review revealed Resident #13 was admitted to the facility on 10/6/16 with diagnoses including Osteoporosis, Femur Fracture, Humerus Fracture, Hypertension, and Anxiety.

Medical record review of the MAR on 10/19/16 revealed Resident #13 was ordered
a. Valsartan (antihypertensive) 40 mg at 9:00 AM
b. Lovenox (prevent blood clotting) 30 mg due at 9:00 AM

Observation during the medication pass revealed RN #3 administered both medications at 11:45 AM.

There were 21 medications given more than 1 hour before or 1 hour after the scheduled time with 32 medications observed during medication pass for a medication error rate of 65%.

Interview with RN #3 on 10/19/16 at 12:30 PM on Hall #1 revealed she was aware she was late administering her medications but also stated "...I would rather my residents be safe..." Continued

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{F 224}	Continued From page 32	{F 224}		

interview revealed RN #3 stated medications are signed off as soon as they are administered because to wait until the end of med pass would be too confusing and difficult to remember if any medications were held.

Interview with the Director of Nursing (DON) on 10/19/16 at 4:05 PM in the conference room revealed she was aware medications were being administered outside the 2 hours window (60 minutes before and 60 minutes after the scheduled time) allotted for medication administration. Continued interview with the DON confirmed medications, blood glucose monitoring, and insulin were administered at times greater than the 2 hours window allowed. Further interview with the DON confirmed it was a medication error for medications to be administered more than 1 hour before or 1 hour after the scheduled time.

Refer to F157 K

Validation of the Allegation of Compliance was completed on-site on 11/14/16 through 11/15/16 by review of facility documentation, medical record reviews, and interviews with Nursing and Administration Staff. Surveyors verified the Allegation of Compliance by:

1. Review of the facility's in-service skills competency training records dated 10/26/16 through 10/29/16 to ensure 100% of nursing staff were educated regarding notification of the physician and responsible party for blood sugar results outside the physician ordered high/low range, following physician orders of administration of all medications and notification of physician for any variances from orders,

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{F 224}	Continued From page 33 including anti-hypertensives and cardiac medication parameters and physician notification of holding medication only as ordered and per the medication administration policy. 2. Verification through interview with 8 licensed and registered nurses conducted 11/14/16 from 1:40 PM through 5:00 PM and 11/15/16 from 6:30 AM through 8:30 AM of the nurse's understanding of the facility's policies regarding following physician orders, administering medications within the physician prescribed parameters with specific attention to insulin, antihypertensive's, and cardiac medications and notification of the physician when medications are held. 3. Observation of 3 nurses on 2 shifts during medication pass on 11/15/16 to verify medications were administered within the scheduled time frame, the correct parameters for blood pressure and pulse were followed for anti-hypertensives and cardiac medications, blood sugars were checked and insulin administered within the scheduled time frames, and notification of the physician if the blood pressure, pulse or blood sugar was outside the prescribed parameter. 8 residents were observed with 46 opportunities for error with no errors observed. 4. Review of 18 resident charts on 10/14/16 and 10/15/16 to verify documentation of vital signs and blood sugars; verification medications were administered within the scheduled time frames, and notification of the physician and responsible party if indicated. 5. Verification through interviews, and review of facility documentation on 11/14/16 and 11/15/16	{F 224}		

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{F 224}	Continued From page 34 of daily chart audits started on 10/17/16 to include documentation of blood pressure, pulse, and blood sugars outside the physician ordered high/low range and notification of the physician and responsible party. 6. Verification through interviews with the Administrator on 11/15/16 at 10:40 AM, in the conference room of the monthly QA meeting held 10/13/16 and 9 Ad Hoc (Immediate) QA meetings since 10/17/16. The facility will remain out of compliance at a Scope and Severity level "F", Substandard Quality of Care; a deficient practice that constitutes immediate jeopardy to residents safety or a pattern of widespread harm that is not immediate jeopardy, or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 224}	**F281- Professional Standards of Practice** **1)** The Administrator terminated the contractual agreement with the former Medical Director on 10/25/16 and entered into a new contractual agreement with a new Medical Director and NP on 10/24/16 to be effective on 10/25/16. (Please refer to F157 Tab 1) RI # 2 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia or negative outcome regarding tube feeding. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended discontinuation of Lorantadine, Miralax and PRN Clonidine and d/c nifedipine TID .	**11/17/16**
{F 281} SS=F	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to meet professional standards "to administer medications properly and in a timely fashion; to communicate a significant change in the resident's condition to the appropriate professional; and to implement a physician's,	{F 281}		

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{F 281}	Continued From page 35 advanced nurse practitioner's, or physician's assistant's order in a timely fashion" (Lippincott Manual of Nursing Practice, 10th Edition, published 2014) by failing to complete blood glucose testing as ordered by the physician for 9 residents (#2, #3, #4, #5, #6, #7, #8, #9, #10) of 9 diabetic residents reviewed; failed to administer insulin per physician's order for 7 residents (#2, #3, #5, #6, #7, #8, #9) of 7 residents receiving insulin; failed to administer cardiac and blood pressure medications as ordered by the physician for 3 residents (#3, #6, #7) of 3 residents reviewed for cardiac and blood pressure medications; failed to administer antidepressant and antianxiety medications as ordered by the physician for 3 residents (#8, #9, #10) of 3 residents receiving antidepressants; and failed to follow guidelines for care of a resident with a wound vac for 1 resident (#18) of 7 residents reviewed with wound care. These failures placed all residents in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 10/24/16 at 3:25 PM in the Conference Room. The facility provided an acceptable Allegation of Compliance with a compliance date of 11/7/16 and a revisit survey conducted 11/14/16 through 11/15/16 revealed the corrective actions implemented removed the Immediacy of the Jeopardy. Noncompliance for F-281 continues at a "F" level for the facility's monitoring the effectiveness of	{F 281}	The New Medical Director/Nurse Practitioner reviewed the recommendations and accepted as recommended and the Medication Administrator records were updated on11/2/16 by the Licensed Nurse. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 7, 8, 9, & 10} RI # 3 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended to change medication administration times which were approved for Renvela and Midodrine to 6pm, 2pm, and 10pm and change Prednisone to 8am. The New Medical Director/Nurse Practitioner reviewed the recommendations and accepted as recommended and the Medication Administrator records were updated on11/2/16 by the Licensed Nurse. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10, 28, 29, 30}	

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{F 281}	Continued From page 36 corrective actions in order to ensure sustained compliance and evaluation of the systemic processes instituted by the facility. The findings included: Review of facility policy, Medication Administration, revised 3/16/15 revealed, "...Administer medications within 60 minutes of the scheduled time..." Review of facility policy, Diabetes, Nursing Care of the Adult Diabetes Mellitus Resident, undated, revealed, "...The purpose of this guideline is...Prevent recurrence of hyperglycemia/hypoglycemia [high and low blood sugars]. Recognize, assist and document the treatment of complications commonly associated with diabetes...obtain pre-meal fingerstick blood glucose within 60 minutes (maximum) of anticipated meal...The physician should be notified when the blood sugar falls above his/her specified blood sugar range and/or above 400 mg/dL (milligrams per deciliter)..." Review of facility policy, Negative Pressure Wound Therapy (NPWT), undated, revealed, "...Review health care provider's orders for frequency of dressing change, type of foam to use, amount of negative pressure and cycle (intermittent or continuous)...Routinely check that the vacuum level is set as prescribed and the dressing is properly sealed...Inspect condition of wound on ongoing basis; note drainage and odor...verify airtight dressing seal and correct negative pressure setting. Measure wound drainage output in canister...Chart in the nurses's	{F 281}	RI # 4 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia or negative outcome regarding tube feeding. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16. The new Medical Director reassessed the resident on 11/1/16 with new orders received.. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibits 35, 36, 37, & 10} RI # 5- No longer resides at the facility. RI #6 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended a change in administration time for Lipitor to be administered at 8:00 pm and requested clarification for Mucinex order to PRN	

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{F 281}	Continued From page 37 notes the appearance of wound, color, characteristics of any drainage...NPWT pressure setting, dressing change, and resident response to dressing change..." The Medical Director of the facility is the physician of record for all the residents. Medical record review revealed Resident #2 was admitted to the facility on 6/3/16 with diagnoses including Hypertension, Encephalopathy, Convulsions, Diabetes Mellitus Type II, Mixed Receptive Expressive Language Disorder, Cerebral Vascular Accident, and Dysphagia. Medical record review of the Quarterly Minimum Data Set (MDS) dated 9/9/16 revealed the resident had a Brief Interview for Mental Status (BIMS) of 4 indicating the resident was severely cognitively impaired. She had continuous behaviors of inattention that did not change, and had rejected care 1-3 days of the previous 7 days. Continued review revealed the resident received 51% or more of her calories, 500 cc (cubic centimeters) or more of fluid through a feeding tube, and received 7 injections of insulin during the previous 7 days. The resident was impaired to her bilateral lower extremities, and impaired on her left upper extremity. She used a wheelchair for ambulation. Observation on 10/11/16 at 1:15 PM, in Resident #2's room revealed Licensed Practical Nurse (LPN) #1 was preparing to administer a bolus tube feeding to the resident. Continued observation revealed the LPN administered 300 cc of Glucerna 1.5 and 240 cc of water through the PEG tube without first checking placement or checking for residual.	{F 281}	every 12 hours verses BID scheduled. The new Medical Director reassessed the resident on 11/1/16 and d/c the Mucinex. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibits 10, 11, 12, 13, & 14} RI # 7 - No longer resides at the facility. RI # 8 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 with some recommendations. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibits 10, 15, 16, 17, & 18} RI # 9 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome	

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{F 281}	Continued From page 38 Interview with LPN #1 on 10/11/16 at 1:25 PM at the medication cart outside room #121 B confirmed she did not check placement or residual prior to administering 300 cc of Glucerna 1.5 tube feeding or 240 cc of water. The LPN confirmed she did not follow the care plan as directed for Resident #2. Medical record review of Physician's Orders for Resident #2 dated 9/22/16 revealed an order for Lantus (long acting insulin) 21 Units subcutaneously at bedtime every night. This order was discontinued on 9/26/16 and Lantus was increased to 24 Units subcutaneously at bedtime every night. The scheduled administration time was 9:00 PM. Medical record review of the 9/2016 and 10/2016 Medication Administration Record (MAR) revealed no Lantus insulin was administered to Resident #2 on 9/22/16 and was administered at 11:25 PM on 10/19/16 instead of 9:00 PM as ordered. Interview with Registered Nurse (RN) #2 by phone on 10/12/16 at 3:20 PM confirmed 21 Units of Lantus Insulin was not administered to Resident #2 on 9/22/16 at 9:00 PM as ordered. Medical record review of a Physician's Order dated 6/4/16 revealed, "...ACCUCHECKS [finger stick for blood sugar] BEFORE BOLUS FEEDINGS AND SSI [sliding scale insulin] AS FOLLOWS: 0-59 = CALL MD 60-150=0, 151-200=2u [units], 201-250=4u, 251-300=6u, 301-350=8u, 351-400 = 10u...NOTIFY MD AND RECHECK IN 15 MINUTES..." The scheduled time was 6 AM, 12 PM, 6 PM, and 12 AM daily.	{F 281}	identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibits 10, 31 & 32} RI # 10 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and the new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibits 10, 33, & 34} RI # 18 was assessed by licensed nurse on 10/19/16 vital signs remain stable with no signs of any negative findings regarding Wound Vac {Exhibit 44} then NP reviewed	

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{F 281}	Continued From page 39 Medical record review of the 6/2016 Medication Administration Record (MAR) for Resident #2 revealed a blood sugar of 211 on 6/4/16 at 5:00 PM and no SSI was administered. Continued review revealed blood sugars were checked 1-4 hours late 2 times for the month of 6/2016. Interview with Licensed Practical Nurse (LPN) #3 on 10/18/16 at 2:20 PM, in the conference room revealed he called Nurse Practitioner (NP) #2 on 6/4/16 regarding Resident #2's blood sugar of 211 and was told to hold the SSI dose of 4 units. Continued interview with the LPN confirmed he did not write an order to hold the 4 units of insulin and he did not administer the dose per the sliding scale protocol. Medical record review of the 6/2016 Medication Administration Record (MAR) for Resident #2 revealed the following blood sugars: 591 on 6/4 at 7:30 AM 432 on 6/6 at 6:00 AM 401 on 6/7 at 12:00 AM High on 6/9 at 12:00 PM 456 on 6/12 at 6:00 AM 429 on 6/18 at 6:00 AM Medical record review revealed no notification of the MD or Nurse Practitioner (NP) regarding Resident #2's elevated blood sugars. Medical record review of the 7/2016 MAR revealed blood sugars were checked 19 minutes-3 hours late 5 times for the month of 7/16. The time frame excludes the 60 minute window of time (60 minutes before and 60 minutes after the scheduled time) which is	{F 281}	the resident and verified and signed the telephone orders. {Exhibit 45} The resident was also assessed/evaluated by the New MD on 11/1/16 and found to be in stable condition with no negative outcome identified. {Exhibit 46} Wound Vac was discontinued on 10/26/16. {Exhibit 47} **2)** We acknowledge residents who receive blood glucose monitoring & insulin administration had the potential to be affected by the alleged deficient practice. An audit conducted on 10/17/16 by the Regional Director of Clinical Services of current residents and identified other residents that had the potential to be affected by the alleged deficient practice. {Exhibit 27} We acknowledge residents who receive Cardiac medications had the potential to be affected by the alleged deficient practice. An audit was conducted on 10/31/16 by Regional Director of Clinical Services of current residents and identified other residents that had the potential to be affected by the alleged deficient practice. {Exhibit 42} We acknowledge residents who receive Anti-Hypertensive medications had the potential to be affected by the alleged deficient practice. An audit was conducted on 10/31/16 by Regional Director of Clinical Services of current residents and identified other residents that had the potential to be affected by the alleged deficient practice. {Exhibit 41}	

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{F 281}	Continued From page 40 allowable to administer medication before or after the scheduled time. Medical record review of the 7/2016 MAR revealed the following blood sugars. 564 on 7/1 at 6:00 AM 441 on 7/1 at 12:00 PM 503 on 7/6 at 12:00 AM 489 on 7/9 at 12:00 PM 518 on 7/10 at 12:00 AM 511 on 7/10 at 12:00 PM 405 on 7/12 at 12:00 AM 466 on 7/25 at 6:00 AM 459 on 7/27 at 12:00 AM 436 on 7/31 at 6:00 PM Medical record review revealed no notification of the MD or NP regarding Resident #2's elevated blood sugars. Medical record review of the 8/2016 MAR revealed the following blood sugars. 475 on 8/1 at 12:00 AM 492 on 8/7 at 6:00 PM 456 on 8/20 at 6:00 PM 432 on 8/21 at 6:00 PM 493 on 8/25 at 6:00 PM Medical record review revealed no notification of the MD or NP regarding the elevated blood sugars. Medical record review of the 9/2016 MAR revealed blood sugars were checked 50 minutes-1 hour and 38 minutes late 2 times for the month of 9/16.	{F 281}	We acknowledge residents who receive Enteral feeding & medications had the potential to be affected by the alleged deficient practice. An audit was conducted on 10/31/16 by The Director of Nursing and the Regional Director of Clinical Services of current residents and identified 10 residents that had the potential to be affected by the alleged deficient practice. {Exhibit 48} We acknowledge residents who receive Anti-depressant medications had the potential to be affected by the alleged deficient practice. An audit was conducted on 11/1/16 by Regional Director of Clinical Services of current residents and identified other residents that had the potential to be affected by the alleged deficient practice. {Exhibit 42} The Medication Administration Records for all residents receiving insulin and/or Sliding Scale coverage, Anti-hypertensive medications, Cardiac Medications, Anti-anxiety medications, Anti-Depressant medications and all medications were reviewed for October 2016 by the Regional Director Clinical Service from 10/28/16 thru 11/1/16 to ensure special requirements for high and low parameters were being followed as ordered by the physician and Medication Administration Record's for holes indicating missing medication and failure to follow physician orders. Facility does not currently have any wound vacs in use as of 11/2/16. {Exhibit 49}	

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{F 281}	Continued From page 41 Continued medical record review of the 9/2016 MAR revealed Resident #2's blood sugar was 501 on 9/22 at 12:00 PM and she received 10 units of insulin per the SSI protocol at 2:49 PM. There was no documentation the blood sugar was re-checked in 15 minutes after administration of the 10 units of SSI. The blood sugar was not checked at 6:00 PM per order. The blood sugar was 327 at 12:00 AM on 9/23 and no SSI was administered; the blood sugar was 560 at 6:00 AM and no SSI was administered, the blood sugar was not re-checked in 15 minutes, and the physician was not notified. Continued review revealed no physician orders to hold accuchecks, or SSI in Resident #2's medical record. Telephone interview with LPN #5 on 10/18/16 at 4:00 PM revealed, "(RN #2) gave me report to hold the insulin for lab work in the morning. I should have looked to see the order myself, and I did not call the Doctor when the sugar was 560. I was just going on what I was told." Interview with LPN #6 on 10/19/16 at 7:15 AM, in the conference room confirmed Resident #2's blood sugar was 47 on 9/7/16 and she failed to notify the physician. Medical record review of Resident #2's 10/2016 MAR revealed blood sugars were checked 17 minutes-4 hours and 35 minutes late 8 times from 10/1-10/20/16 and checked 1 hour and 26 minutes early on 10/8/16. Interview with the Director of Nursing (DON) on 10/19/16 at 4:05 PM in the conference room confirmed the facility policy was to notify the physician if a blood sugar was less than 60 or greater than 400. Continued interview revealed	{F 281}	**3)** On 10/26/16 – 10/29/16 the Director of Nursing/Designee provided focused skilled competencies to licensed nurses on Diabetes – including high and low parameters and physician notification for results outside the physician ordered high/low range. Following physician orders for administration of medications and notification of physician for any variances from orders, Anti-hypertensive, Cardiac medication parameters & MD notification of holding medication if ordered and medication administration policy, Wound Vac care and needed orders related to wound vac and enteral nutrition including holding feeding parameters and checking tube placement & residual before instilling any fluids into tube. {Exhibit 26} Since 10/25/16 the facility has hired 6 additional new nurses 2 RNs and 4 LPNs. The Director of Nursing/Designee to conduct an audit of 5 residents receiving blood sugar monitoring with sliding scale &/or insulin administration to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct an audit of 5 residents receiving Anti-Hypertensive medications to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then	

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{F 281}	Continued From page 42 the DON was unaware accuchecks were up to 5 hours late. Further interview with the DON stated, "I knew they were a little late but I had no idea they were 2 1/2-3 hours late. Continued interview with the DON confirmed the facility failed to check blood sugars as ordered, failed to follow the facility policy, and failed to notify the physician of the elevated blood sugars for Resident #2. Interview with the DON on 10/19/16 at 4:05 PM, in the conference room confirmed not administering Lantus Insulin as ordered on 9/22/16 and administering the insulin at 11:25 PM instead of 9:00 PM were medication errors. Continued interview with the DON confirmed the facility failed to follow physician orders for Resident #2. Medical record review revealed Resident #3 was admitted to the facility on 7/5/16 and readmitted on 9/22/16 with diagnoses including Anoxic Brain Injury, Respiratory Failure, Diabetes Mellitus Type II, Chronic Kidney Disease Stage IV, Aphasia, Anxiety, Depression and a History of Multiple Myeloma. Medical record review of an Admission MDS dated 7/12/16 revealed the resident was severely cognitively impaired, had impairments to all extremities, received insulin 1 time over the previous 7 days and received 51% or greater of his calories and 501 cc per day of fluid through a feeding tube. Medical record review of a physician's telephone order dated 9/22/16 revealed, "...Accuchecks before meals and at bedtime..." The scheduled time of administration was 7:30 AM, 12:00 PM, 5:00 PM, and 9:00 PM. The order did not include	{F 281}	monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct an audit of 5 residents receiving Cardiac medications to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct an audit of 5 residents receiving Enteral medications & nutrition to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct Medication Administration Observation to ensure Physician Orders are being followed and Medications are being administered timely with 5 license nurses per week X 4 weeks then monthly X 5 months or until sustained compliance can be reached. Nursing Home Administrator received in-service education by Chief Nursing Officer on the Quality Assurance Performance Improvement Process and how to conduct a root cause analysis and develop a Performance Improvement Plan on 11/15/16. Corporate clinical support conducted daily Medication administration record audits to validate high, low parameters for blood sugars and blood pressures and pulses were followed according to Physician orders. This Audit was conducted 7 days per week at 4am beginning 10/30/16	

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{F 281}	Continued From page 43 sliding scale insulin (SSI) orders. Medical record review of the 9/2016 MAR revealed Resident #3's blood sugar was scheduled to be checked at 9:00 PM and was checked at 11:43 PM on 9/22, and scheduled to be checked at 7:30 AM on 9/23 and was checked at 1:22 PM. Medical record review revealed no physician's telephone orders regarding accuchecks, SSI, or administration time changes. Medical record review of Resident #3's Physician's Recapitulation Orders for 9/2016 revealed an order dated 9/23/16 for accuchecks with SSI. The scheduled times were 10:00 AM, 2:00 PM, 6:00 PM and 10:00 PM. Medical record review of the 9/2016 and 10/2016 MAR revealed blood sugars were checked late as follows for Resident #3: 9/24 scheduled at 10:00 AM checked at 3:05 PM 9/24 scheduled at 2:00 PM checked at 4:20 PM 9/25 scheduled at 10:00 AM checked at 3:38 PM 9/25 scheduled at 2:00 PM checked at 5:33 PM 9/25 scheduled at 10:00 PM checked at 11:23 PM 9/26 scheduled at 10:00 AM checked at 12:39 PM 9/26 scheduled at 2:00 PM checked at 3:28 PM 9/26 scheduled at 10:00 PM checked at 5:20 AM on 9/27 9/28 scheduled at 10:00 AM checked at 11:19 AM 9/28 scheduled at 2:00 PM checked at 4:04 PM 9/28 scheduled at 10:00 PM checked at 11:36 PM 9/29 scheduled at 10:00 AM checked at 3:19 PM 9/29 scheduled at 2:00 PM checked at 3:20 PM 10/4 scheduled at 2:00 PM checked at 6:08 PM	{F 281}	through 11/15/16 and improved compliance has been noted. The facility has initiated a check out process at the end of each shift to validate Licensed nurse is compliant with documentation of Medication administration according to physician orders and notification of any identified results that were out of the set parameters per physician orders. The check-out process started on 11/7/16 by the nursing administration team once sustained compliance is reached the process will be conducted peer to peer at shift change between on-coming nurse and off-going nurse during the shift to shift report process which will include a Medication Administration Review prior to on-coming nurse accepting the keys. Corporate Clinical support continues to randomly review 10 resident Medication Administration Records during their facility visits as a second check to ensure compliance is sustained. (4. (a) The Director of Nursing/Designee will report audit findings to the Quality Assurance Performance Improvement Committee in the bi-weekly meeting for Six months. The Quality Assurance Performance Improvement Committee will review the systematic change and audits during the bi-weekly meetings for six months.	

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{F 281}	Continued From page 44 Medical record review of a physician's telephone order dated 9/12/16 revealed, "...Midodrine HCL [used to treat low blood pressure] 5 mg tab [tablet] give one tab PT [per tube] before meals; BP [blood pressure] to be checked prior to administration, Hold for BP [systolic greater than 120 or diastolic greater than 80]..." The order was written by LPN #4 and signed by NP #1. Medical record review of the Electronic Physician's Order dated 9/12/16 for Midodrine 5 mg revealed it was entered into the computer by LPN #4 at 7:00 PM. The electronic order contained a special requirement to check the blood pressure prior to administration and to hold if the systolic blood pressure was less than 120. Medical record review of Resident #3's 9/2016 MAR revealed a physician's order dated 9/12/16 for "...MIDODRINE HCL 5 MG TABLET give one tablet per tube before meals. CHECK BP [blood pressure]..." There were no blood pressure parameters transcribed onto the MAR. Medical record review of the 9/2016 MAR revealed Midodrine 5 mg was administered to the resident with the following BP documented. 9/12 at 10:00 PM. BP 149/90 9/13 at 10:00 AM. BP 152/82 9/13 at 2:00 PM. BP 125/64 9/13 at 6:00 PM BP 122/80 9/13 at 10:00 PM. BP 124/53 9/14 at 10:00 AM. BP 134/70 9/14 at 2:00 PM. BP 130/70 9/14 at 6:00 PM. BP 134/70 9/14 at 10:00 PM. BP 129/82 9/15 at 10:00 AM. BP 126/75	{F 281}	Some of the Systemic/structural enhancements are: Change in Medical Director, review and approval of new blood glucose protocol, re-organization of medication administration times, pharmacy reviews for 100% of residents to address overall total number of medications per resident, ongoing training and education for medication administration, increase in medication pass reviews, increase cart nurse staffing by (2) FTE on day and evening shifts thereby moving to a (6) cart process, and clinical skills education with return demonstration for 100% of all clinical staff going forward. Any findings with the opportunities for improvement will be analyzed using the fish bone diagram or five why's process to determine the root cause. Once the root cause has been defined, then a more appropriate intervention will be implemented to ensure compliance. (b) The Quality Assurance Performance Improvement Committee, meets at least bi-weekly X 6 months includes the Medical Director, Director of Nursing, Administrator, MDS Coordinator, Social Services, Activities Director and Maintenance. Un-scheduled Quality Assurance Performance Improvement Committee meetings will be held anytime the need is identified through open discussion and/or areas of concern. If non-compliance is identified, the Quality Assurance Performance Improvement Committee will identify the root cause for the non-compliance, develop a plan to	

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{F 281}	Continued From page 45 9/15 at 2:00 PM. BP 128/75 9/16 at 10:00 AM. BP 120/100 9/16 at 2:00 PM. BP 118/88 Continued review of an Electronic Physician's Order dated 9/16/16 revealed LPN #3 removed the parameter to hold the Midodrine 5 mg if the systolic blood pressure was less than 120 on 9/16/16 at 5:01 PM. The original parameters from the 9/12/16 order to hold the medication if the systolic BP was greater than 120 or the diastolic BP was greater than 80 was not entered into the computer or transcribed onto the MAR. Medical record review of the MAR revealed Midodrine 5 mg was administered to Resident #3 from 9/16 at 6:00 PM-9/20 at 6:00 PM without knowledge if the resident was hypotensive and required the medication as there was no documentation of blood pressures during this time frame. Interview with the Regional Nurse on 10/24/16 at 2:00 PM, in the conference room confirmed the facility failed to follow physician orders for Resident's #2 and #3. Medical record review revealed Resident #4 was admitted to the facility on 5/19/14 with diagnoses including Multiple Sclerosis, Diabetes Mellitus, Depression, Hypertension, and Congestive Heart Failure. Medical record review of physician's orders dated 7/26/16 revealed "...Please give 8 ounces Osmolite 1.5 per tube as needed if meal intake is less than 50%..." Continued review of physician orders dated 9/20/16 revealed "...Osmolite 1.5 cal liquid, Give 8 ounces per tube BID (twice daily)	{F 281}	address the non-compliance, study/monitor the plan implemented for its' effectiveness and make changes as indicated. The Committee will continue to monitor interventions for the structural enhancements and monitoring will continue bi-weekly x 6 months. (c). The Regional Director of Clinical Services, Company Director of Regulatory Compliance, or Regional Director of Clinical Compliance will visit the center to attend a monthly quality assurance performance improvement meeting for three months to ensure that the Plan, Do Study, Act process is being followed and remains to be effective and improvements continue to be made. Audits have revealed 2 Nurses that continued to struggle to achieve compliance with expectations regarding Medication Administration and Notification processes put in place and have since been terminated and additional 2 nurses received one on one education regarding expectations and subsequently have been placed on Performance Improvement Plans that are being reviewed weekly with the Director of Nursing services.	

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{F 281}	Continued From page 46 between meals with 120 ml (milliliters) H2O flush before and after each bolus..." Medical record review of the MAR for October 2016 revealed the 8 ounces of Osmolite were administered at 10:00 AM and 10:00 PM. Continued review revealed the 8 ounces to be given with food intake less than 50% was scheduled for 9:00 AM, 1:00 PM, and 7:00 PM. Further review of the MAR revealed the feeding was checked off as given at all times regardless of the amount consumed at each meal. Medical record review of nursing notes for 10/2016 revealed no documentation the Osmolite was given between meals as ordered. Interview with LPN #7 on 10/17/16 at 3:05 PM, in the conference room revealed she documented the amount the resident ate and put a check mark to indicate she was aware of the amount the resident ate. Continued interview revealed if the resident ate less than 50% of the meal the nurse would administer Osmolite to the resident. Interview with LPN #3 on 10/17/16 at 3:11 PM, in the conference room revealed nurses place a check mark on the MAR to indicate they were aware of the amount the resident ate. Continued interview revealed if the resident ate less than 50% the staff would give Osmolite because that was the order. Further interview revealed LPN #3 was not aware of any place to document the Osmolite when it was given. Continued interview revealed "...If the amount the resident eats is less than 50% we assume the nurse administered the Osmolite..." Medical record review of the MAR for October	{F 281}		

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{F 281}	Continued From page 47 2016 revealed on 21 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window. Medical record review revealed Resident #5 was admitted to the facility on 10/9/16 with diagnoses including Congestive Heart Failure, End Stage Renal Disease, Hypertension, Diabetes Mellitus, and Anxiety. Medical record review of the MAR for October revealed: a. on 7 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 4 occasions insulin was administered 1 1/2 - 2 hours past the scheduled window c. on 6 occasions Metformin was administered 1 1/2 - 3 hours past the scheduled window. Medical record review revealed Resident #6 was admitted to the facility on 9/11/15 and readmitted on 9/19/16 with diagnoses including Schizophrenia, Bipolar Disorder, Diabetes Mellitus, Acute Kidney Failure, Diabetes Insipidus, Hypertension, Gastroesophageal Reflux Disease, and Dementia. Medical record review of the Medication Administration Record (MAR) for September 2016 revealed: a. on 22 occasions blood glucose monitoring was completed from 1 1/2 - 7 hours past the scheduled window b. on 12 occasions insulin was administered 1 1/2 - 7 hours past the scheduled window c. on 7 occasions Rocephin (antibiotic) was administered 2 - 8 1/2 hours past the scheduled window.	{F 281}		

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{F 281}	Continued From page 48 Medical record review of the MAR for October 2016 revealed: a. on 33 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 2 occasions insulin was administered 1/2 - 1 1/2 hours past the scheduled window c. on 4 occasions Cymbalta (antidepressant) was administered 2 - 3 hours past the scheduled window d. on 4 occasions Trazodone (antidepressant) was administered 1/2 - 3 hours past the scheduled window e. on 9 occasions Buspirone (anti-anxiety) was administered 1 1/2 - 4 hours past the scheduled window Medical record review revealed Resident #7 was admitted to the facility on 9/29/16 and readmitted on 9/30/16 with diagnoses including Congestive Heart Failure, Cellulitis Left Lower Extremity, Atherosclerotic Cardiovascular Disease, Benign Prostatic Hypertrophy, Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Cor Pulmonale, Atrial Flutter, Chronic Kidney Disease Stage III, and Chronic Obstructive Pulmonary Disease. Medical record review of the MAR for October 2016 revealed: a. on 18 occasions blood glucose monitoring was completed 1 1/2 - 3 hours past the scheduled window b. on 16 occasions insulin was administered 2 1/2 - 8 hours past the scheduled window c. on 5 occasions Cardizem (cardiac) was administered 3 1/2 - 6 hours past the scheduled window	{F 281}		

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{F 281}	Continued From page 49 d. on 9 occasions Metoprolol (blood pressure) was administered 1 1/2 - 3 hours past the scheduled window e. on 5 occasions Lisinopril (blood pressure) was administered 1 1/2 - 3 hours past the scheduled window f. on 3 occasions Elavil (antianxiety) was administered 1 1/2 - 2 1/2 hours past the scheduled window Medical record review revealed Resident #8 was admitted to the facility on 6/29/16 and readmitted on 8/16/16 with diagnoses including Diabetes Mellitus, Hypertension, Obstructive Sleep Apnea, Seizures, Dysphagia, Gastroesophageal Reflux Disease, and Chronic Pain. Medical record review of the MAR for September revealed: a. on 54 occasions blood glucose monitoring was completed 1 1/2 - 8 1/2 hours past the scheduled window b. on 18 occasions Clonidine (blood pressure) was administered 1 1/2 - 5 hours past the scheduled window c. on 13 occasions Celexa (antidepressant) was administered 1 1/2 - 5 1/2 hours past the scheduled window d. on 14 occasions Trazodone (antidepressant) was administered 1 1/2 - 4 1/2 hours past the scheduled window e. on 3 occasions Coreg (cardiac) was administered 1 1/2 - 2 1/2 hours past the scheduled window f. on 1 occasion Lexothyroxine (thyroid) and Zantac (antacid) were administered 10 1/2 hours past the scheduled window Medical record review of the MAR for October	{F 281}		

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{F 281}	Continued From page 50 2016 revealed: a. on 31 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 4 occasions insulin was administered 2 - 5 hours past the scheduled window c. on 20 occasions Clonidine was administered 1 1/2 - 7 /12 hours past the scheduled window d. on 11 occasions Celexa was administered 2 - 3 hours past the scheduled window e. on 13 occasions Trazodone was administered 1 1/2 - 5 hours past the scheduled window. Medical record review revealed Resident #9 was admitted to the facility on 4/22/16 and readmitted on 5/11/16 with diagnoses including Acute/Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Obstructive Sleep Apnea, Atrial Fibrillation, Hypertension, Congestive Heart Failure, Seizures, Dementia, and Atherosclerotic Cardiovascular Disease. Medical record review of the MAR for September 2016 revealed: a. on 30 occasions blood glucose monitoring was completed 1 1/2 - 7 hours past the scheduled window b. on 20 occasions insulin was administered 1 1/2 - 7 hours past the scheduled window. c. on 43 occasions Buspirone (antianxiety) was administered 1 1/2 - 5 hours past the scheduled window d. on 16 occasions Cymbalta (antidepressant) was administered 1 1/2 - 5 hours past the scheduled window e. on 16 occasions Trazodone (antidepressant) was administered 1 1/2 - 5 hours past the scheduled window.	{F 281}		

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{F 281}	Continued From page 51	{F 281}		

Medical record review of the MAR for October 2016 revealed:
a. on 13 occasions blood glucose monitoring was completed 1 1/2 - 4 hours past the scheduled window
b. on 6 occasions insulin was administered 1 1/2 - 3 1/2 hours past the scheduled window
c. on 19 occasions Buspirone was administered 1 1/2 - 2 1/2 hours past the scheduled window
d. on 8 occasions Cymbalta was administered 1 1/2 - 3 1/2 hours past the scheduled window
e. on 8 occasions Trazodone was administered 1 1/2 hours - 3 1/2 hours past the scheduled window

Medical record review revealed Resident #10 was admitted to the facility on 5/6/16 with diagnoses including Hypertension, Diabetes Mellitus, Dementia, Atherosclerotic Cardiovascular Disease, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Ischemic Cardiomyopathy, and Bipolar Disorder.

Medical record review of the MAR for September 2016 revealed:
a. on 47 occasions blood glucose monitoring was completed 1 1/2 - 7 hours past the scheduled window

Medical record review of the MAR for October 2016 revealed:
a. on 34 occasions blood glucose monitoring was completed 1 1/2 - 7 1/2 hours past the scheduled window.

Interview with the Director of Nursing (DON) on 10/20/16 at 4:40 PM in the Conference Room,

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{F 281}	Continued From page 52 confirmed medications were administered outside the window of 60 minutes before and 60 minutes after the scheduled time. Continued interview confirmed blood glucose monitoring and insulin administration occurred outside the window. Medical record review revealed Resident #18 was admitted to the facility on 3/25/14 and readmitted on 1/11/16 with diagnoses including Dementia, Dysthymic Disorder, Parkinson's, Hypertension, Coronary Artery Disease and Anemia. Medical record review of a Quarterly MDS dated 7/8/16 revealed the resident was severely cognitively impaired, always incontinent of bowel and bladder and had a Stage IV pressure ulcer to the sacrum. Medical record review of a telephone physician's order dated 10/10/16 prescribed by NP #3 revealed, "...Coccyx pressure area - NPWT to pack/fill woundbed & drape to seal...Continue AG Collagen to cover coccyx wound bed each Vac [change]..." Medical record review of the Treatment Administration Record (TAR) for 10/16 revealed the order was not followed on 10/11 or 10/12. Observation of Resident #18 on 10/18/16 at 10:20 AM in the resident's room revealed the resident was in bed, eyes closed. A wound vac was present to the side rail with serous drainage noted. Interview with the Wound Nurse on 10/19/16 at 11:30 AM in Hermitage Hall when asked when the resident's wound vac was placed stated, "Friday." (10/14). Continued interview revealed when	{F 281}		

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{F 281}	Continued From page 53	{F 281}		

asked what the treatment order dated 10/10 meant the Wound Nurse stated, "that the wound vac was there." Continued interview revealed the Wound Nurse confirmed she documented care of the resident and the wound vac on 10/13, 10/14, 10/17, 10/18, and 10/19. Further review revealed there was no additional documentation of when the wound vac was placed, the negative pressure setting, how often it was to be changed, amount and color of drainage or how the resident was tolerating it. The Wound Nurse stated, "I should have documented all of that."

Interview with the DON on 10/19/16 at 4:05 PM in the conference room confirmed the Wound Nurse should have clarified the 10/10/16 treatment order for the wound vac to Resident #18 on 10/10/16, "and most certainly when the wound vac was placed." Continued interview with the DON confirmed there should have been documentation of the amount, color and odor of drainage, how the resident was tolerating the wound vac, the amount of negative pressure the wound vac was set on, and the type of wound vac machine and there was not.

Interview with LPN #8 on 10/20/16 at 1:00 PM in the conference room confirmed she had cared for the resident on 10/15/16 and had documented on the TAR she had followed the treatment order dated 10/10/16. When asked what the protocol was for care of a resident with a wound vac she stated, "It is changed every Monday, Wednesday, and Friday and it is done by the Treatment (Wound) Nurse." When asked what her documentation of the order meant, she stated, "I've never changed a wound vac before. I checked that it was there." The LPN confirmed she did not provide any care, or documentation of

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{F 281}	Continued From page 54 the wound, or wound vac for Resident #18. Telephone interview with LPN #11 on 10/20/16 at 4:50 PM confirmed she had cared for the resident on 10/16/16. When asked what care she provided to the resident she stated, "He had a wound vac to his sacrum. I changed the tape. The wound was exposed and I secured the dressing with tape." The LPN confirmed she did not change the dressing, or document the status of the wound, wound vac settings, drainage type and amount, or how the resident was tolerating the care. Refer to F157 K, F224 L SQC Validation of the Allegation of Compliance was completed on-site on 11/14/16 through 11/15/16 by review of facility documentation, medical record reviews, and interviews with Nursing and Administration Staff. Surveyors verified the Allegation of Compliance by: 1. Review of the facility's in-service skills competency training records dated 10/26/16 through 10/29/16 to ensure 100% of nursing staff were educated regarding notification of the physician and responsible party for blood sugar results outside the physician ordered high/low range, following physician orders of administration of all medications and notification of physician for any variances from orders, including anti-hypertensives and cardiac medication parameters and physician notification of holding medication only as ordered and per the medication administration policy. 2. Verification through interview with 8 licensed and registered nurses conducted 11/14/16 from 1:40 PM through 5:00 PM and 11/15/16 from 6:30	{F 281}		

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{F 281}	Continued From page 55 AM through 8:30 AM of the nurse's understanding of the facility's policies regarding following physician orders, administering medications within the physician prescribed parameters with specific attention to insulin, antianxiety, antidepressants, antihypertensive's, and cardiac medications and notification of the physician when medications are held. 3. Observation of 3 nurses on 2 shifts during medication pass on 11/15/16 to verify medications were administered within the scheduled time frame including antianxiety, and antidepressant medications, the correct parameters for blood pressure and pulse were followed for anti-hypertensives and cardiac medications, blood sugars were checked and insulin administered within the scheduled time frames, and notification of the physician if the blood pressure, pulse or blood sugar was outside the prescribed parameter. 8 residents were observed with 46 opportunities for error with no errors observed. 4. Review of 18 resident charts on 10/14/16 and 10/15/16 to verify documentation of vital signs and blood sugars; verification medications were administered within the scheduled time frames, and notification of the physician and responsible party if indicated. No resident was receiving wound vac treatment. 5. Verification through interviews, and review of facility documentation on 11/14/16 and 11/15/16 of daily chart audits started on 10/17/16 to include documentation of blood pressure, pulse, and blood sugars outside the physician ordered high/low range and notification of the physician and responsible party.	{F 281}		

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{F 281}	Continued From page 56 6. Verification through interviews with the Administrator on 11/15/16 at 10:40 AM, in the conference room of the monthly QA meeting held 10/13/16 and 9 Ad Hoc (Immediate) QA meetings since 10/17/16. The facility will remain out of compliance at a Scope and Severity level "F" until it provides an acceptable plan of correction and corrections are verified on-site.	{F 281}	**F282- Service provided by a qualified person per plan of care** **1)** RI # 2 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia or negative outcome regarding tube feeding. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended discontinuation of Lorantadine, Miralax and PRN Clonidine and d/c nifedipine TID . The New Medical Director/Nurse Practitioner reviewed the recommendations and accepted as recommended and the Medication Administrator records were updated on11/2/16 by the Licensed Nurse. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 7, 8, 9, & 10} RI # 3 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was	**11/17/16**
{F 282} SS=F	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to provide care in accordance with the resident's Plan of Care by failing to complete blood glucose testing as outlined in the care plan for 9 residents (#2, #3, #4, #5, #6, #7, #8, #9, #10) of 9 diabetic residents reviewed; failed to administer insulin as outlined in the care plan for 7 residents (#2, #3, #5, #6, #7, #8, #9) of 7 residents receiving insulin; failed to administer cardiac and blood pressure medications as outlined in the care plan for 3 residents (#3, #6, #7) of 3 residents reviewed for cardiac and blood pressure medications; failed to administer antidepressant and antianxiety medications as outlined in the care plan for 3 residents (#8, #9, #10) of 3 residents receiving	{F 282}		

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{F 282}	Continued From page 57 antidepressants; and failed to follow guidelines for care of a resident with a wound vac for 1 resident (#18) of 1 resident with a wound vac. These failures placed all residents in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Administrator (NHA) was informed of the Immediate Jeopardy on 10/24/16 at 3:25 PM, in the Conference Room. The facility provided an acceptable Allegation of Compliance with a compliance date of 11/7/16 and a revisit survey conducted 11/14/16 through 11/15/16 revealed the corrective actions implemented removed the Immediacy of the Jeopardy. Noncompliance for F-282 continues at a "F" level, Substandard Quality of Care, for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the systemic processes instituted by the facility. The findings included: Review of facility policy, Medication Administration, revised 3/16/15 revealed, "...Administer medications within 60 minutes of the scheduled time..." Review of facility policy, Diabetes, Nursing Care of the Adult Diabetes Mellitus Resident, undated,	{F 282}	assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended changes were reviewed and approved. The New Medical Director/Nurse Practitioner reviewed the recommendations and accepted as recommended and the Medication Administrator records were updated on11/2/16 by the Licensed Nurse. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 28, 29, 10 & 30} RI # 4 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia or negative outcome regarding tube feeding. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended changes and those were accepted by physician and completed by the licensed nurse. The new Medical Director reassessed the resident	

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{F 282}	Continued From page 58 revealed, "...The purpose of this guideline is...Prevent recurrence of hyperglycemia/hypoglycemia [high and low blood sugars]. Recognize, assist and document the treatment of complications commonly associated with diabetes...obtain pre-meal fingerstick blood glucose within 60 minutes (maximum) of anticipated meal...The physician should be notified when the blood sugar falls above his/her specified blood sugar range and/or above 400 mg/dL (milligrams per deciliter)..." Review of facility policy, Negative Pressure Wound Therapy (NPWT), undated, revealed, "...Review health care provider's orders for frequency of dressing change, type of foam to use, amount of negative pressure and cycle (intermittent or continuous)...Routinely check that the vacuum level is set as prescribed and the dressing is properly sealed...Inspect condition of wound on ongoing basis; note drainage and odor...verify airtight dressing seal and correct negative pressure setting. Measure wound drainage output in canister...Chart in the nurses's notes the appearance of wound, color, characteristics of any drainage...NPWT pressure setting, dressing change, and resident response to dressing change..." The Medical Director of the facility is the physician of record for all the residents. Medical record review revealed Resident #2 was admitted to the facility on 6/3/16 with diagnoses including Hypertension, Encephalopathy, Convulsions, Diabetes Mellitus Type II, Mixed Receptive Expressive Language Disorder, Cerebral Vascular Accident, and Dysphagia.	{F 282}	on 11/1/16 new orders received. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit {10, 35, 36, & 37} RI # 5- No longer resides at the facility. RI #6 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended a change in administration time for Lipitor to be administered at 8:00 pm and requested clarification for Mucinex order to PRN every 12 hours verses BID scheduled. The new Medical Director reassessed the resident on 11/1/16 with some new orders received. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10, 11, 12, 13, & 14} RI # 7 - No longer resides at the facility. RI # 8 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was	

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{F 282}	Continued From page 59 Medical record review of the Quarterly Minimum Data Set (MDS) dated 9/9/16 revealed the resident had a Brief Interview for Mental Status (BIMS) of 4 indicating the resident was severely cognitively impaired. She had continuous behaviors of inattention that did not change and had rejected care 1-3 days of the previous 7 days. Continued review revealed the resident received 51% or more of her calories, 500 cc (cubic centimeters) or more of fluid through a feeding tube, and received 7 injections of insulin during the previous 7 days. The resident was impaired to her bilateral lower extremities, and impaired on her left upper extremity. She used a wheelchair for ambulation. Medical record review of a comprehensive care plan for Resident #2 dated 6/8/16 revealed a problem of a PEG tube (Percutaneous Endoscopic Gastrostomy - feeding tube) for adequate nutritional intake. Interventions included: "...Check placement before initiating my tube feedings; Check for residual before initiating my feeding; Tube feeding and flushes per order..." Observation on 10/11/16 at 1:15 PM, in Resident #2's room revealed Licensed Practical Nurse (LPN) #1 was preparing to administer a bolus tube feeding to the resident. Continued observation revealed the LPN administered 300 cc of Glucerna 1.5 and 240 cc of water through the PEG tube without first checking placement, or checking for residual. Interview with LPN #1 on 10/11/16 at 1:25 PM at the medication cart outside room #121 B confirmed she did not check placement or	{F 282}	assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 and recommended and changes were made. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10, 15, 16, 17, & 18} RI # 9 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 with no new changes per the new physician. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10, 31, 32}	

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{F 282}	Continued From page 60 residual prior to administering 300 cc of Glucerna 1.5 tube feeding or 240 cc of water. The LPN confirmed she did not follow the care plan as directed for Resident #2. Medical record review of a comprehensive care plan dated 6/7/16 revealed a problem of medical management for Diabetes Mellitus Type II. Interventions included, "...Administer my scheduled insulin as ordered; Obtain my finger stick blood sugars as ordered ..." Medical record review of Physician's Orders dated 9/22/16 revealed an order for Lantus (long acting insulin) 21 Units subcutaneously at bedtime every night. This order was discontinued on 9/26/16 and Lantus was increased to 24 Units subcutaneously at bedtime every night. The scheduled administration time was 9:00 PM. Medical record review of the 9/2016 and 10/2016 Medication Administration Record (MAR) revealed no Lantus insulin was administered to Resident #2 on 9/22/16 and was administered at 11:25 PM on 10/19/16 instead of 9:00 PM as ordered. Interview with Registered Nurse (RN) #2 by phone on 10/12/16 at 3:20 PM confirmed 21 Units of Lantus Insulin was not administered to Resident #2 on 9/22/16 at 9:00 PM as ordered. Medical record review of a Physician's Order dated 6/4/16 revealed, "...ACCUCHECKS [finger stick for blood sugar] BEFORE BOLUS FEEDINGS AND SSI [sliding scale insulin] AS FOLLOWS: 0-59 = CALL MD 60-150=0, 151-200=2u [units], 201-250=4u, 251-300=6u, 301-350=8u, 351-400 = 10u...NOTIFY MD AND	{F 282}	RI # 10 Medication Administration Record was reviewed by licensed nurse on 10-31-16 vital signs remain stable with no signs of hyper/hypoglycemia. The former Medical Director was notified and resident was assessed/evaluated by the MD/NP on 10/14/16 and found to be in stable condition with no negative outcome identified. The Physician determined that the High Parameter for blood sugar checks needed to be increased to 500 threshold on 10/18/16. The Pharmacy Consultant conducted a Medication Regimen Review on 10/25/16 with no new order changes. The new Medical Director reassessed the resident on 11/1/16 with no new orders. The Resident Responsible Party was notified of the medication variance on 11/2/16 by a licensed nurse. {Exhibit 10, 33, 34} RI # 18 was assessed by licensed nurse on 10/19/16 vital signs remain stable with no signs of any negative findings regarding Wound Vac then NP reviewed the resident and verified the orders. Was also assessed/evaluated by the New MD/NP on 11/1/16 and found to be in stable condition with no negative outcome identified. Wound Vac was discontinued on10/26/16. {Exhibit 10, 44, 45, 46, & 47}	

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{F 282}	Continued From page 61 RECHECK IN 15 MINUTES..." The scheduled time was 6 AM, 12 PM, 6 PM, and 12 AM daily. Medical record review of Resident #2's 6/2016 Medication Administration Record (MAR) revealed a blood sugar of 211 on 6/4/16 at 5:00 PM and no SSI was administered. Continued review revealed blood sugars were checked 1-4 hours late 2 times for the month of 6/2016. Interview with Licensed Practical Nurse (LPN) #3 on 10/18/16 at 2:20 PM, in the conference room revealed he called Nurse Practitioner (NP) #2 on 6/4/16 regarding Resident's #2's blood sugar of 211 and was told to hold the SSI dose of 4 units. Continued interview with the LPN confirmed he did not write an order to hold the 4 units of insulin and he did not administer the dose per the sliding scale protocol. Medical record review of the 6/2016 Medication Administration Record (MAR) for Resident #2 revealed the following blood sugars: 591 on 6/4 at 7:30 AM 432 on 6/6 at 6:00 AM 401 on 6/7 at 12:00 AM High on 6/9 at 12:00 PM 456 on 6/12 at 6:00 AM 429 on 6/18 at 6:00 AM Medical record review revealed no notification of the MD or Nurse Practitioner (NP) regarding Resident #2's elevated blood sugars. Medical record review of the 7/2016 MAR revealed blood sugars were checked 19 minutes-3 hours late 5 times for the month of 7/2016. The time frame excludes the 60 minute	{F 282}	2) We acknowledge residents who reside at the facility who receive medications, enteral feedings, blood glucose monitoring, that experience a change in condition or receive a change in plan of care had the potential to be affected by the alleged deficient practice. Resident's with physician orders for insulin, Anti-hypertensive medications, Cardiac medications, Anti-Anxiety medications, Anti-Depressant medications, Anti-Seizure Medications and Wound Vacs care plans were reviewed and updated to reflect their current needs. This Care plan review/update was conducted 10/28/16 through 11/1/16 by the Regional Director of Clinical Compliance and MDS Nurses. {Exhibit 50} 3) The Regional Director of Clinical Compliance provided in-service education to the facility MDS nurses regarding the expectation of updating care plans with changes in condition on 10/25/16. {Exhibit 51} On 10/26/16 to 10/29/16 the Director of Nursing/Designee provided focused in-service competencies to licensed nurses on Diabetes, including high and low parameters and physician notification for results outside the physician ordered high/low range. Following physician orders for administration of medications and	

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{F 282}	Continued From page 62 window of time (60 minutes before and 60 minutes after the scheduled time) which is allowable to administer medication before or after the scheduled time. Medical record review of Resident #2's 7/2016 MAR revealed the following blood sugars. 564 on 7/1 at 6:00 AM 441 on 7/1 at 12:00 PM 503 on 7/6 at 12:00 AM 489 on 7/9 at 12:00 PM 518 on 7/10 at 12:00 AM 511 on 7/10 at 12:00 PM 405 on 7/12 at 12:00 AM 466 on 7/25 at 6:00 AM 459 on 7/27 at 12:00 AM 436 on 7/31 at 6:00 PM Medical record review revealed no notification of the MD or NP regarding Resident #2's elevated blood sugars. Medical record review of the 8/16 MAR revealed the following blood sugars. 475 on 8/1 at 12:00 AM 492 on 8/7 at 6:00 PM 456 on 8/20 at 6:00 PM 432 on 8/21 at 6:00 PM 493 on 8/25 at 6:00 PM Medical record review revealed no notification to the MD or NP regarding Resident #2's elevated blood sugars. Medical record review of the 9/2016 MAR revealed blood sugars were checked 50 minutes-1 hour and 38 minutes late 2 times for	{F 282}	notification of physician for any variances from orders, Anti-hypertensive, Cardiac medication parameters & MD notification of holding medication if ordered and medication administration policy, Wound Vac care and needed orders related to wound vac and enteral nutrition including holding feeding parameters and checking tube placement & residual before instilling any fluids into tube. Education provided included the expectation of following the plan of care. {Exhibit 26} Since 10/25/16 the facility has hired 6 additional new nurses 2 RNs and 4 LPNs. The Director of Nursing/Designee to conduct an audit of 5 residents receiving blood sugar monitoring with sliding scale &/or insulin administration to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct an audit of 5 residents receiving Anti-Hypertensive medications to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct an audit of 5 residents receiving Cardiac medications to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly	

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{F 282}	Continued From page 63 the month of 9/16. Continued medical record review of the 9/2016 MAR revealed the resident's blood sugar was 501 on 9/22 at 12:00 PM and she received 10 units of insulin per the SSI protocol at 2:49 PM. There was no documentation the blood sugar was re-checked in 15 minutes after administration of the 10 units of SSI. Resident #2's blood sugar was not checked at 6:00 PM per order. The blood sugar was 327 at 12:00 AM on 9/23 and no SSI was administered; the blood sugar was 560 at 6:00 AM and no SSI was administered, the blood sugar was not re-checked in 15 minutes, and the physician was not notified. Continued review revealed no physician orders to hold accuchecks, or SSI in Resident #2's medical record. Telephone interview with LPN #5 on 10/18/16 at 4:00 PM revealed, "(RN #2) gave me report to hold the insulin for lab work in the morning. I should have looked to see the order myself, and I did not call the Doctor when the sugar was 560. I was just going on what I was told." Interview with LPN #6 on 10/19/16 at 7:15 AM, in the conference room confirmed Resident #2's blood sugar was 47 on 9/7/16 and she failed to notify the physician. Medical record review of the 10/2016 MAR revealed Resident #2's blood sugars were checked 17 minutes-4 hours and 35 minutes late 8 times from 10/1-10/20/16 and checked 1 hour and 26 minutes early on 10/8/16. Interview with the Director of Nursing (DON) on 10/19/16 at 4:05 PM, in the conference room confirmed the facility policy was to notify the	{F 282}	X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct an audit of 5 residents receiving Enteral medications & nutrition to ensure physician orders for administration and notification are being followed. This audit will be conducted weekly X 4 weeks then monthly X 5 months or until sustained compliance can be reached. The Director of Nursing/Designee to conduct Medication Administration Observation to ensure Physician Orders are being followed and Medications are being administered timely with 5 license nurses per week X 4 weeks then monthly X 5 months or until sustained compliance can be reached. Nursing Home Administrator received in-service education by Chief Nursing Officer on the Quality Assurance Performance Improvement Process and how to conduct a root cause analysis and develop a Performance Improvement Plan on 11/15/16. Corporate clinical support conducted daily Medication administration record audits to validate high, low parameters for blood sugars and blood pressures and pulses were followed according to Physician orders. This Audit was conducted 7 days per week at 4am beginning 10/30/16 through 11/15/16 and improved compliance has been noted. The facility has initiated a check out process at the end of each shift to validate	

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{F 282}	Continued From page 64 physician if a blood sugar was less than 60 or greater than 400. Continued interview revealed the DON was unaware accuchecks were up to 5 hours late. Further interview with the DON revealed "I knew they were a little late but I had no idea they were 2 1/2-3 hours late. Continued interview with the DON confirmed the facility failed to check blood sugars as ordered, failed to follow the facility policy, and failed to notify the physician of Resident #2's elevated blood sugars. Interview with the DON on 10/19/16 at 4:05 PM, in the conference room confirmed not administering Lantus Insulin as ordered on 9/22/16 and administering the insulin at 11:25 PM instead of 9:00 PM were medication errors. Continued interview with the DON confirmed the facility failed to follow physician orders. Medical record review revealed Resident #3 was admitted to the facility on 7/5/16 and readmitted on 9/22/16 with diagnoses including Anoxic Brain Injury, Respiratory Failure, Diabetes Mellitus Type II, Chronic Kidney Disease Stage IV, Aphasia, Anxiety, Depression and a History of Multiple Myeloma. Medical record review of an Admission MDS dated 7/12/16 revealed the resident was severely cognitively impaired, had impairments to all extremities, received insulin 1 time over the previous 7 days and received 51% or greater of his calories and 501 cc per day of fluid through a feeding tube. Medical record review of the comprehensive care plan dated 7/19/16 revealed a problem of insulin dependent diabetes. Interventions included, "...Administer my insulin according to my	{F 282}	Licensed nurse is compliant with documentation of Medication administration according to physician orders and notification of any identified results that were out of the set parameters per physician orders. The check out process started on 11/7/16 by the nursing administration team once sustained compliance is reached the process will be conducted peer to peer at shift change between on-coming nurse and off-going nurse during the shift to shift report process which will include a Medication Administration Review prior to on-coming nurse accepting the keys. Corporate Clinical support continues to randomly review 10 resident Medication Administration Records during their facility visits as a second check to ensure compliance is sustained. (4. (a) The Director of Nursing/Designee will report audit findings to the Quality Assurance Performance Improvement Committee in the bi-weekly meeting for Six months. The Quality Assurance Performance Improvement Committee will review the systematic change and audits during the bi-weekly meetings for six months. The Quality Assurance Performance Improvement Committee will review the systematic change and audit bi-weekly for six months.	

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{F 282}	Continued From page 65 physician's orders; Monitor my blood sugars per my physician's orders..." Medical record review of a physician's telephone order dated 9/22/16 revealed, "...Accuchecks before meals and at bedtime..." The scheduled time of administration was 7:30 AM, 12:00 PM, 5:00 PM, and 9:00 PM. The order did not include sliding scale insulin (SSI) orders. Medical record review of the 9/2016 MAR revealed Resident #3's blood sugar was scheduled to be checked at 9:00 PM and was checked at 11:43 PM on 9/22, and scheduled to be checked at 7:30 AM on 9/23 and was checked at 1:22 PM. Medical record review revealed no physician's telephone orders regarding accuchecks, SSI, or administration time changes. Medical record review of the Physician's Recapitulation Orders for 9/2016 revealed an order dated 9/23/16 for accuchecks with SSI. The scheduled times were 10:00 AM, 2:00 PM, 6:00 PM and 10:00 PM. Medical record review of the 9/2016 and 10/2016 MAR revealed blood sugars were checked late as follows for Resident #3: 9/24 scheduled at 10:00 AM checked at 3:05 PM 9/24 scheduled at 2:00 PM checked at 4:20 PM 9/25 scheduled at 10:00 AM checked at 3:38 PM 9/25 scheduled at 2:00 PM checked at 5:33 PM 9/25 scheduled at 10:00 PM checked at 11:23 PM 9/26 scheduled at 10:00 AM checked at 12:39 PM 9/26 scheduled at 2:00 PM checked at 3:28 PM	{F 282}	Some of the Systemic/structural enhancements are: Change in Medical Director, review and approval of new blood glucose protocol, re-organization of medication administration times, pharmacy reviews for 100% of residents to address overall total number of medications per resident, ongoing training and education for medication administration, increase in medication pass reviews, increase cart nurse staffing by (2) FTE on day and evening shifts thereby moving to a (6) cart process, and clinical skills education with return demonstration for 100% of all clinical staff going forward. Any findings with the opportunities for improvement will be analyzed using the fish bone diagram or five why's process to determine the root cause. Once the root cause has been defined, then a more appropriate intervention will be implemented to ensure compliance. (b) The Quality Assurance Performance Improvement Committee, meets bi-weekly, includes the Medical Director, Director of Nursing, Administrator, MDS Coordinator, Social Services, Activities Director and Maintenance. Un-scheduled Quality Assurance Performance Improvement Committee meetings will be held anytime the need is identified through open discussion and/or areas of concern. If non-compliance is identified, the Quality Assurance Performance Improvement Committee will identify the root cause for the non-compliance, develop a plan to address the non-compliance, study/monitor the plan	

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{F 282}	Continued From page 66 9/26 scheduled at 10:00 PM checked at 5:20 AM on 9/27 9/28 scheduled at 10:00 AM checked at 11:19 AM 9/28 scheduled at 2:00 PM checked at 4:04 PM 9/28 scheduled at 10:00 PM checked at 11:36 PM 9/29 scheduled at 10:00 AM checked at 3:19 PM 9/29 scheduled at 2:00 PM checked at 3:20 PM 10/4 scheduled at 2:00 PM checked at 6:08 PM Medical record review of the comprehensive care plan dated 7/19/16 revealed a problem of signs of congestive heart failure. Interventions included: "...Administer my cardiac...meds [medications] as ordered..." Medical record review of a physician's telephone order dated 9/12/16 revealed, "...Midodrine HCL [used to treat low blood pressure] 5 mg tab [tablet] give one tab PT [per tube] before meals; BP [blood pressure] to be checked prior to administration, Hold for BP [systolic greater than 120 or diastolic greater than 80]..." The order was written by LPN #4 and signed by NP #1. Medical record review of the Electronic Physician's Order dated 9/12/16 for Midodrine 5 mg revealed it was entered into the computer by LPN #4 at 7:00 PM. The electronic order contained a special requirement to check the blood pressure prior to administration and to hold if the systolic blood pressure was less than 120. Medical record review of 9/2016 MAR revealed a physician's order dated 9/12/16 for "...MIDODRINE HCL 5 MG TABLET give one tablet per tube before meals. CHECK BP [blood pressure]..." There were no blood pressure parameters transcribed onto the MAR.	{F 282}	implemented for its' effectiveness and make changes as indicated. The Committee will continue to monitor interventions for the structural enhancements and monitoring will continue bi-weekly x 5 months. (c). The Regional Director of Clinical Services, Company Director of Regulatory Compliance, or Regional Director of Clinical Compliance will visit the center to attend a monthly quality assurance performance improvement meeting for three months to ensure that the Plan, Do Study, Act process is being followed and remains to be effective and improvements continue to be made. Audits have revealed 2 Nurses that continued to struggle to achieve compliance with expectations regarding Medication Administration and Notification processes put in place and have since been terminated and addition of 2 nurses received one on one education regarding expectations and subsequently have been placed on Performance Improvement Plans that are being reviewed weekly with the Director of Nursing Services.	

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{F 282}	Continued From page 67 Medical record review of the 9/2016 MAR revealed Midodrine 5 mg was administered to the resident with the following BP documented. 9/12 at 10:00 PM. BP 149/90 9/13 at 10:00 AM. BP 152/82 9/13 at 2:00 PM. BP 125/64 9/13 at 6:00 PM BP 122/80 9/13 at 10:00 PM. BP 124/53 9/14 at 10:00 AM. BP 134/70 9/14 at 2:00 PM. BP 130/70 9/14 at 6:00 PM. BP 134/70 9/14 at 10:00 PM. BP 129/82 9/15 at 10:00 AM. BP 126/75 9/15 at 2:00 PM. BP 128/75 9/16 at 10:00 AM. BP 120/100 9/16 at 2:00 PM. BP 118/88 Continued review of an Electronic Physician's Order dated 9/16/16 revealed LPN #3 removed the parameter to hold the Midodrine 5 mg if the systolic blood pressure was less than 120 on 9/16/16 at 5:01 PM. The original parameters from the 9/12/16 order to hold the medication if the systolic BP was greater than 120 or the diastolic BP was greater than 80 was not entered into the computer or transcribed onto the MAR. Medical record review of the MAR revealed Midodrine 5 mg was administered to Resident #3 from 9/16 at 6:00 PM-9/20 at 6:00 PM without knowledge if the resident was hypotensive and required the medication as there was no documentation of blood pressures during this time frame. Interview with the Regional Nurse on 10/24/16 at 2:00 PM in the conference room confirmed the facility failed to follow physician orders for	{F 282}		

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{F 282}	Continued From page 68 Resident's #2 and #3. Medical record review revealed Resident #4 was admitted to the facility on 5/19/14 with diagnoses including Multiple Sclerosis, Diabetes Mellitus, Depression, Hypertension, and Congestive Heart Failure. Medical record review of physician's orders dated 7/26/16 revealed "...Please give 8 ounces Osmolite 1.5 per tube as needed if meal intake is less than 50%..." Continued review of physician orders dated 9/20/16 revealed "...Osmolite 1.5 cal liquid, Give 8 ounces per tube BID (twice daily) between meals with 120 ml (milliliters) H2O flush before and after each bolus..." Medical record review of the MAR for October 2016, revealed the 8 ounces of Osmolite were administered at 10:00 AM and 10:00 PM. Continued review revealed the 8 ounces to be given with food intake less than 50% was scheduled for 9:00 AM, 1:00 PM, and 7:00 PM. Further review of the MAR revealed the feeding was checked off as given at all times regardless of the amount consumed at each meal. Medical record review of nursing notes for October 2016 revealed no documentation the Osmolite was given between meals as ordered. Interview with LPN #7 on 10/17/16 at 3:05 PM, in the conference room revealed she documented the amount the resident ate and put a check mark to indicate she was aware of the amount the resident ate. Continued interview revealed if the resident ate less than 50% of the meal the nurse would administer Osmolite to the resident.	{F 282}		

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{F 282}	Continued From page 69 Interview with LPN #3 on 10/17/16 at 3:11 PM, in the conference room revealed nurses place a check mark on the MAR to indicate they were aware of the amount the resident ate. Continued interview revealed if the resident ate less than 50% the staff would give Osmolite because that was the order. Further interview revealed LPN #3 was not aware of any place to document the Osmolite when it was given. Continued interview revealed "...If the amount the resident eats is less than 50% we assume the nurse administered the Osmolite..." Medical record review of the care plan for Resident #4, revised 9/22/16 revealed a problem of "I have labile blood sugars related to Type II Diabetes Mellitus." Continued review revealed Approaches included: a. Monitor my nutritional intake. b. Obtain my finger stick blood sugars as ordered. c. Administer my oral hypoglycemic agents as ordered. Medical record review of the MAR for October 2016 revealed: a. on 21 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window. Medical record review revealed Resident #5 was admitted to the facility on 10/9/16 with diagnoses including Congestive Heart Failure, End Stage Renal Disease, Hypertension, Diabetes Mellitus, and Anxiety. Medical record review of the Interim Care Plan initiated 10/9/16 revealed a problem of "Resident required insulin injections to manager Diabetes."	{F 282}		

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{F 282}	Continued From page 70 Continued review revealed Approaches included: a. Administer routine and sliding scale insulin as per physician's orders. b. Administer finger sticks as ordered and give sliding scale insulin as per physician's orders c. Observe for signs/symptoms of hypo/hyperglycemia and report to physician as per parameters. Medical record review of the MAR for 10/2016 revealed: a. on 7 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 4 occasions insulin was administered 1 1/2 - 2 hours past the scheduled window c. on 6 occasions Metformin was administered 1 1/2 - 3 hours past the scheduled window. Medical record review revealed Resident #6 was admitted to the facility on 9/11/15 and readmitted on 9/19/16 with diagnoses including Schizophrenia, Bipolar Disorder, Diabetes Mellitus, Acute Kidney Failure, Diabetes Insipidus, Hypertension, Gastroesophageal Reflux Disease, and Dementia. Medical record review of the Care Plan with a problem onset dated 9/30/16 of "I am insulin dependent diabetic." Continued review of the care plan revealed Approaches included: a. Administer my insulin according to my physician's orders. b. Monitor my blood sugars per my physician's orders. c. Observe me for signs/ symptoms of hypo/hyperglycemia and report any noted to physician.	{F 282}		

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{F 282}	Continued From page 71 Medical record review of the Care Plan revealed a problem onset of 5/19/14 of "I am at risk for side effects from psychotropic drug use." Continued review revealed Approaches included: a. Administer my medication as ordered by physician. b. Observe me for adverse side effects, document, and report to my physician. Medical record review of the Medication Administration Record (MAR) for September 2016 revealed: a. on 22 occasions blood glucose monitoring was completed from 1 1/2 - 7 hours past the scheduled window b. on 12 occasions insulin was administered 1 1/2 - 7 hours past the scheduled window c. on 7 occasions Rocephin (antibiotic) was administered 2 - 8 1/2 hours past the scheduled window. Medical record review of the MAR for October 2016 revealed: a. on 33 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 2 occasions insulin was administered 1/2 - 1 1/2 hours past the scheduled window c. on 4 occasions Cymbalta (antidepressant) was administered 2 - 3 hours past the scheduled window d. on 4 occasions Trazodone (antidepressant) was administered 1/2 - 3 hours past the scheduled window e. on 9 occasions Buspirone (anti-anxiety) was administered 1 1/2 - 4 hours past the scheduled window Medical record review revealed Resident #7 was	{F 282}		

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{F 282}	Continued From page 72 admitted to the facility on 9/29/16 and readmitted on 9/30/16 with diagnoses including Congestive Heart Failure, Cellulitis Left Lower Extremity, Atherosclerotic Cardiovascular Disease, Benign Prostatic Hypertrophy, Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Cor Pulmonale, Atrial Flutter, Chronic Kidney Disease Stage III, and Chronic Obstructive Pulmonary Disease. Medical record review of the Care Plan revealed a problem onset of 10/12/16 of "I am insulin dependent diabetic." Continued review revealed Approaches included: a. Administer my insulin according to my physician's orders. b. Monitor my blood sugars per my physician's orders. c. Observe me for signs/symptoms of hypo/hyperglycemia and report any noted to my physician. Medical record review revealed a problem onset of 10/12/16 of "I am at risk for altered cardiac status related to Cor Pulmonale, Hypertension, and Congestive Heart Failure." Continued review revealed Approaches of: a. Medication as ordered. b. Report signs/symptoms of side effects. Medical record review of the MAR for October 2016 revealed: a. on 18 occasions blood glucose monitoring was completed 1 1/2 - 3 hours past the scheduled window b. on 16 occasions insulin was administered 2 1/2 - 8 hours past the scheduled window c. on 5 occasions Cardizem (cardiac) was administered 3 1/2 - 6 hours past the scheduled	{F 282}		

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{F 282}	Continued From page 73	{F 282}		

window
d. on 9 occasions Metoprolol (blood pressure) was administered 1 1/2 - 3 hours past the scheduled window
e. on 5 occasions Lisinopril (blood pressure) was administered 1 1/2 - 3 hours past the scheduled window
f. on 3 occasions Elavil (antianxiety) was administered 1 1/2 - 2 1/2 hours past the scheduled window

Medical record review revealed Resident #8 was admitted to the facility on 6/29/16 and readmitted on 8/16/16 with diagnoses including Diabetes Mellitus, Hypertension, Obstructive Sleep Apnea, Seizures, Dysphagia, Gastroesophageal Reflux Disease, and Chronic Pain.

Medical record review of the Care Plan revealed a problem onset of 8/4/16 of "I am an insulin dependent diabetic." Continued review revealed Approaches included:
a. Administer my insulin according to my physician's orders.
b. Monitor my blood sugars per my physician's orders.
c. Observe me for signs/symptoms of hypo/hyperglycemia and report any noted to my physician.

Medical record review of the Care Plan revealed a problem onset of 8/4/16 of "I am at risk for side effects from antidepressant drug use." Continued review revealed Approaches of:
a. Administer my medication as ordered by physician.

Medical record review of the MAR for 9/2016 revealed:

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{F 282}	Continued From page 74 a. on 54 occasions blood glucose monitoring was completed 1 1/2 - 8 1/2 hours past the scheduled window b. on 18 occasions Clonidine (blood pressure) was administered 1 1/2 - 5 hours past the scheduled window c. on 13 occasions Celexa (antidepressant) was administered 1 1/2 - 5 1/2 hours past the scheduled window d. on 14 occasions Trazodone (antidepressant) was administered 1 1/2 - 4 1/2 hours past the scheduled window e. on 3 occasions Coreg (cardiac) was administered 1 1/2 - 2 1/2 hours past the scheduled window f. on 1 occasion Lexothyroxine (thyroid) and Zantac (antacid) were administered 10 1/2 hours past the scheduled window Medical record review of the MAR for 10/2016 revealed: a. on 31 occasions blood glucose monitoring was completed 1 1/2 - 5 1/2 hours past the scheduled window b. on 4 occasions insulin was administered 2 - 5 hours past the scheduled window c. on 20 occasions Clonidine was administered 1 1/2 - 7 /12 hours past the scheduled window d. on 11 occasions Celexa was administered 2 - 3 hours past the scheduled window e. on 13 occasions Trazodone was administered 1 1/2 - 5 hours past the scheduled window. Medical record review revealed Resident #9 was admitted to the facility on 4/22/16 and readmitted on 5/11/16 with diagnoses including Acute/Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Obstructive Sleep Apnea, Atrial	{F 282}		

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{F 282}	Continued From page 75 Fibrillation, Hypertension, Congestive Heart Failure, Seizures, Dementia, and Atherosclerotic Cardiovascular Disease. Medical record review of the Care Plan revealed a problem onset of 5/4/16 of "I am an insulin dependent diabetic." Continued review revealed Approaches included: a. Administer my insulin according to my physician's orders. b. Monitor my blood sugars per my physician's orders. c. Observe me for signs/symptoms of hypo/hyperglycemia and report any noted to my physician. Medical record review of the Care Plan revealed a problem onset of 5/4/16 of "I am at risk for side effects from psychotropic drug use related to antidepressant and antianxiety medication. Continued review revealed approaches of: a. Administer my medications as ordered by physician. Medical record review of the MAR for 9/2016 revealed: a. on 30 occasions blood glucose monitoring was completed 1 1/2 - 7 hours past the scheduled window b. on 20 occasions insulin was administered 1 1/2 - 7 hours past the scheduled window. c. on 43 occasions Buspirone (antianxiety) was administered 1 1/2 - 5 hours past the scheduled window d. on 16 occasions Cymbalta (antidepressant) was administered 1 1/2 - 5 hours past the scheduled window e. on 16 occasions Trazodone (antidepressant) was administered 1 1/2 - 5 hours past the	{F 282}		

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{F 282}	Continued From page 76 scheduled window. Medical record review of the MAR for 10/2016 revealed: a. on 13 occasions blood glucose monitoring was completed 1 1/2 - 4 hours past the scheduled window b. on 6 occasions insulin was administered 1 1/2 - 3 1/2 hours past the scheduled window c. on 19 occasions Buspirone was administered 1 1/2 - 2 1/2 hours past the scheduled window d. on 8 occasions Cymbalta was administered 1 1/2 - 3 1/2 hours past the scheduled window e. on 8 occasions Trazodone was administered 1 1/2 hours - 3 1/2 hours past the scheduled window Medical record review revealed Resident #10 was admitted to the facility on 5/6/16 with diagnoses including Hypertension, Diabetes Mellitus, Dementia, Atherosclerotic Cardiovascular Disease, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Ischemic Cardiomyopathy, and Bipolar Disorder. Medical record review of the MAR for 9/2016 revealed: a. on 47 occasions blood glucose monitoring was completed 1 1/2 - 7 hours past the scheduled window Medical record review of the MAR for 10/2016 revealed: a. on 34 occasions blood glucose monitoring was completed 1 1/2 - 7 1/2 hours past the scheduled window. Interview with the Director of Nursing (DON) on	{F 282}		

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{F 282}	Continued From page 77 10/20/16 at 4:40 PM, in the Conference Room confirmed medications were administered outside the window of 60 minutes before and 60 minutes after the scheduled time. Continued interview confirmed blood glucose monitoring and insulin administration occurred outside the window. Medical record review revealed Resident #18 was admitted to the facility on 3/25/14 and readmitted on 1/11/16 with diagnoses including Dementia, Dysthymic Disorder, Parkinson's, Hypertension, Coronary Artery Disease and Anemia. Medical record review of a Quarterly MDS dated 7/8/16 revealed the resident was severely cognitively impaired, always incontinent of bowel and bladder and had a Stage IV pressure ulcer to the sacrum. Medical record review of a telephone physician's order dated 10/10/16 prescribed by NP #3 revealed, "...Coccyx pressure area - NPWT to pack/fill woundbed & drape to seal...Continue AG Collagen to cover coccyx wound bed each Vac [change]..." Medical record review of the Treatment Administration Record (TAR) for 10/16 revealed the order was not followed on 10/11 or 10/12. Observation of Resident #18 on 10/18/16 at 10:20 AM in the resident's room revealed the resident was in bed, eyes closed. A wound vac was present to the side rail with serous drainage noted. Interview with the Wound Nurse on 10/19/16 at 11:30 AM, in Hermitage Hall when asked when the resident's wound vac was placed stated,	{F 282}		

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{F 282}	Continued From page 78 "Friday." (10/14). Continued interview revealed when asked what the treatment order dated 10/10 meant the Wound Nurse stated, "that the wound vac was there." Continued interview revealed the Wound Nurse confirmed she documented care of the resident and the wound vac on 10/13, 10/14, 10/17, 10/18, and 10/19. Further review revealed there was no additional documentation of when the wound vac was placed, the negative pressure setting, how often it was to be changed, amount and color of drainage or how the resident was tolerating it. The Wound Nurse stated, "I should have documented all of that." Interview with the DON on 10/19/16 at 4:05 PM, in the conference room confirmed the Wound Nurse should have clarified the 10/10/16 treatment order for the wound vac to Resident #18 on 10/10/16, "and most certainly when the wound vac was placed." Continued interview with the DON confirmed there should have been documentation of the amount, color and odor of drainage, how the resident was tolerating the wound vac, the amount of negative pressure the wound vac was set on, and the type of wound vac machine and there was not. Interview with LPN #8 on 10/20/16 at 1:00 PM, in the conference room confirmed she had cared for the resident on 10/15/16 and had documented on the TAR she had followed the treatment order dated 10/10/16. When asked what the protocol was for care of a resident with a wound vac she stated, "It is changed every Monday, Wednesday, and Friday and it is done by the Treatment (Wound) Nurse." When asked what her documentation of the order meant, she stated, "I've never changed a wound vac before. I checked that it was there." The LPN confirmed	{F 282}		

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{F 282}	Continued From page 79 she did not provide any care, or documentation of the wound, or wound vac for Resident #18. Telephone interview with LPN #11 on 10/20/16 at 4:50 PM confirmed she had cared for the resident on 10/16/16. When asked what care she provided to the resident she stated, " He had a wound vac to his sacrum. I changed the tape. The wound was exposed and I secured the dressing with tape." The LPN confirmed she did not change the dressing, or document the status of the wound, wound vac settings, drainage type and amount, or how the resident was tolerating the care. Refer to F157 K, F224 L SQC, F281 L. Validation of the Allegation of Compliance was completed on-site on 11/14/16 through 11/15/16 by review of facility documentation, medical record reviews, and interviews with Nursing and Administration Staff. Surveyors verified the Allegation of Compliance by: 1. Review of the facility's in-service skills competency training records dated 10/26/16 through 10/29/16 to ensure 100% of nursing staff were educated regarding notification of the physician and responsible party for blood sugar results outside the physician ordered high/low range, following physician orders of administration of all medications and notification of physician for any variances from orders, including anti-hypertensives and cardiac medication parameters, physician notification of holding medication only as ordered and per the medication administration policy, and care of a resident with a wound vac.	{F 282}		

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{F 282}	Continued From page 80 2. Verification through interview with 8 licensed and registered nurses conducted 11/14/16 from 1:40 PM through 5:00 PM and 11/15/16 from 6:30 AM through 8:30 AM of the nurse's understanding of the facility's policies regarding following physician orders, administering medications within the physician prescribed parameters with specific attention to insulin, antianxiety, antidepressants, antihypertensive's, and cardiac medications, notification of the physician when medications are held, and care of a resident with a wound vac. 3. Observation of 3 nurses on 2 shifts during medication pass on 11/15/16 to verify medications were administered within the scheduled time frame including antianxiety, and antidepressant medications, the correct parameters for blood pressure and pulse were followed for anti-hypertensives and cardiac medications, blood sugars were checked and insulin administered within the scheduled time frames, and notification of the physician if the blood pressure, pulse or blood sugar was outside the prescribed parameter. 8 residents were observed with 46 opportunities for error with no errors observed. 4. Review of 18 resident charts on 10/14/16 and 10/15/16 to verify documentation of vital signs and blood sugars; verification medications were administered within the scheduled time frames, and notification of the physician and responsible party if indicated. No resident was receiving wound vac treatment. 5. Verification through interviews, and review of facility documentation on 11/14/16 and 11/15/16 of daily chart audits started on 10/17/16 to include	{F 282}		